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Hospital Library

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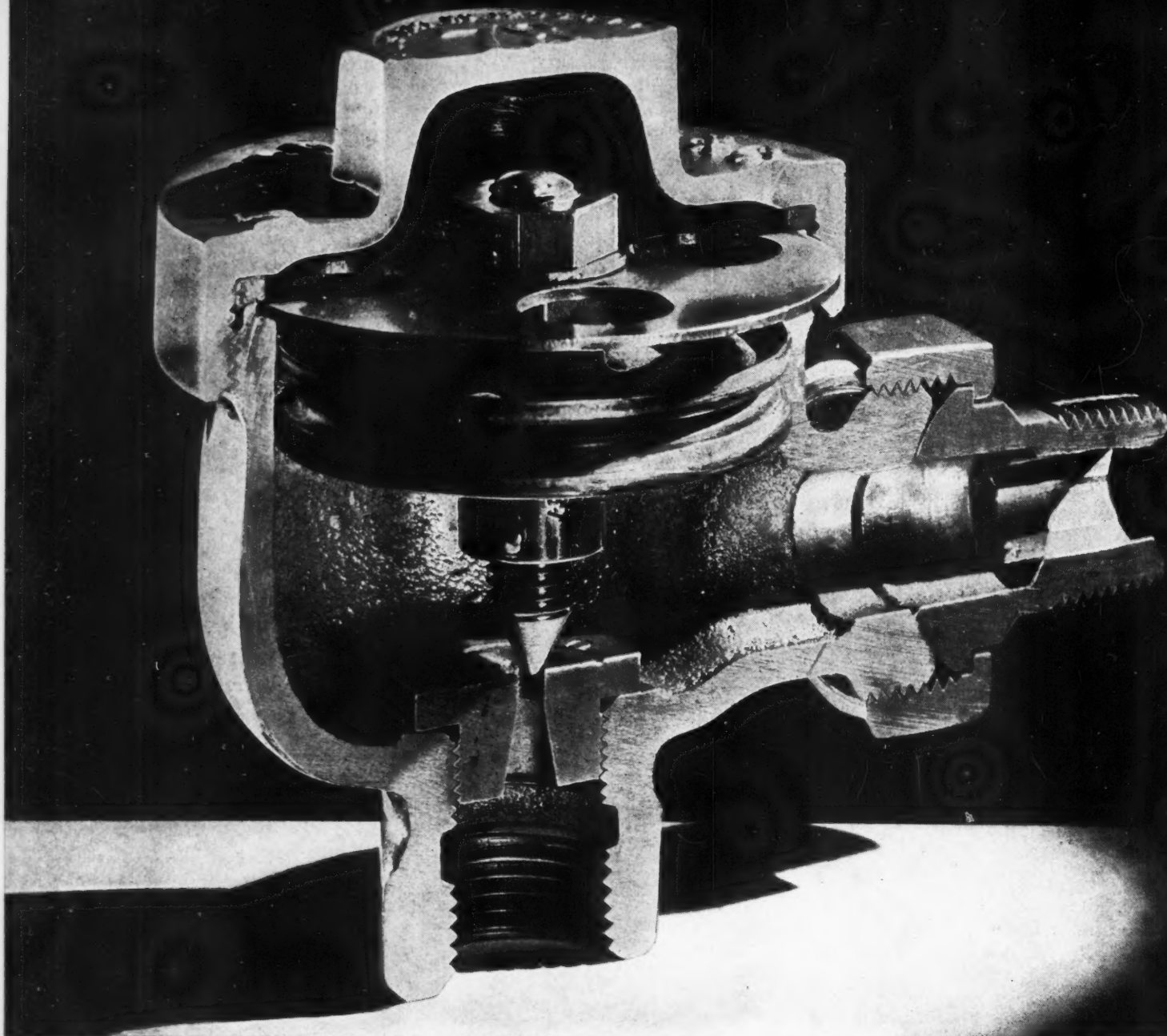


*the*  
MODERN  
HOSPITAL

VOLUME 53

OCTOBER 1939

NUMBER 4



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For October 1939

Just in Passing—

**Cover Page**—View of new sanatorium of Uppsala County in Uppsala, Sweden. Gustaf Birch-Lindgren was the architect.

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WHILE trying desperately to keep out of the European War, the United States must not be caught unprepared for such an eventuality. Doctor MacEachern's article on page 56 is one of several that MODERN HOSPITAL readers may expect on hospital preparedness. Next month either Doctor MacEachern or an officer of the U. S. Medical Corps, or possibly both, will outline next steps for hospitals to take in a campaign of intelligent preparedness.

THE department of anesthesia is growing in importance in the hospital organization. It will fulfill its full function only if properly organized and well staffed. Next month we shall begin a series of three articles on this important subject by Gertrude Fife. Administrators and anesthetists will find them of absorbing interest.

WE PUBLISHED in September an interesting article on the modernizing of St. Clare's Hospital, New York City. Next month we take a transcontinental hop and get another article on modernization from the Pacific Coast. R. E. Heerman has written a first-rate story on an excellent five year modernization program at California Hospital, Los Angeles.

IN OUR series of articles on interrelationships between the administration and the medical staff we turn next month to the pediatrics department. Unusually fortunate do we count ourselves in the choice of an author. Dr. Albert W. Snoke is not only a pediatrician but also assistant administrator of Strong Memorial Hospital. He approaches the problem with a clear understanding of the viewpoint of both parties.

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**Y**OU have doubtless heard much recently about using green drapes over the patient in the operating room. Dr. W. J. Engel of the Cleveland Clinic will report next month on some intensive research into the subject of the best color for operating rooms. You will find his material challenging and may want to try out his suggestions.

**Y**OU may remember the recent article by Ethel Kawin on play therapy. Now a nurse comes to give her side of the same subject. Queenie Mills will talk to you next month through these columns on toys and play materials that are suitable for sick children.

**D**R. GEORGE DICK of the University of Chicago has devoted much time to a study of the value of ultraviolet radiation in disinfecting hospital rooms. He presents his conclusions in an interesting article scheduled for the November issue.

**D**O YOU have an organized personnel department? If so, please let James A. Hamilton, New Haven Hospital, New Haven, Conn., know about it and give him an idea of the functioning of the department. Even if the personnel director is part-time, he would like to have the information.

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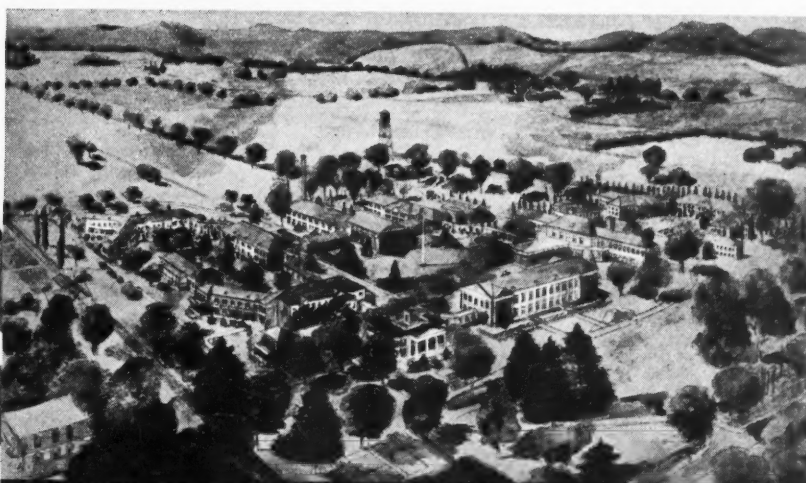
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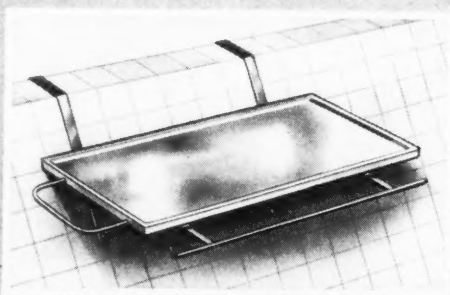


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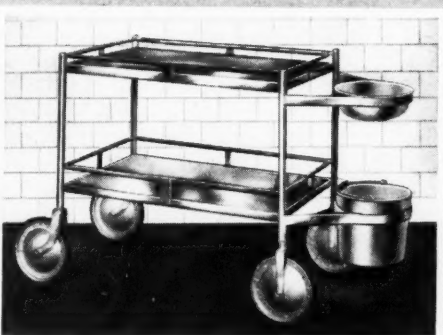
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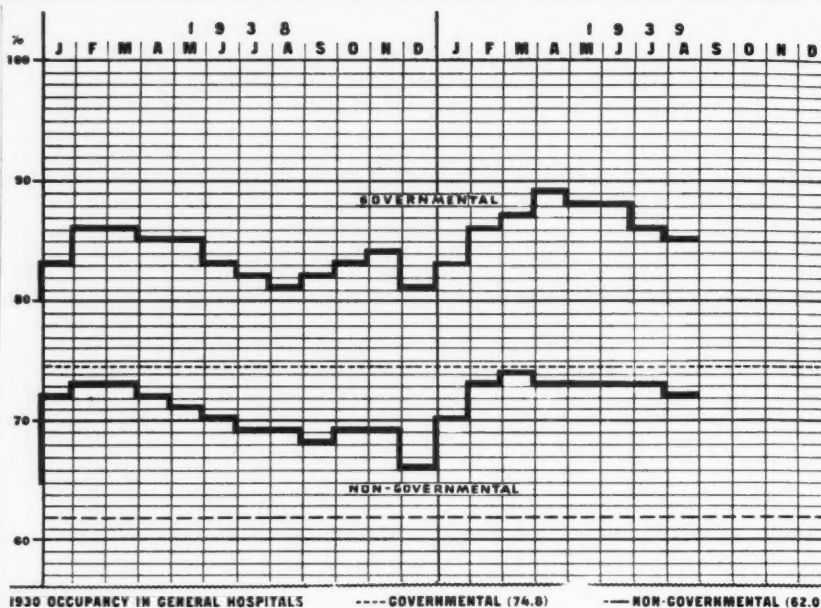


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# HOSPITAL OCCUPANCY BAROMETER

	Census Data on Reporting Hospitals		1939		1938	
Type and Place	Hosp. <sup>1</sup>	Beds <sup>2</sup>	July	June	July	June
Government						
New York City.....	17	10,873	96*	96	92	95
New Jersey.....	4	2,236	89*	89*	85	91
Washington, D. C.....	1	1,220	70*	70*	70*	70*
N. and S. Carolina.....	18	2,084	74	73	73	71
New Orleans.....	2	2,466	102	114	94	96
San Francisco.....	3	2,255	94	93	86	87
St. Paul.....	1	850	66*	66	65	64
Chicago.....	1	3,300	85	91	85	86
Total <sup>4</sup> .....	47	25,281	85*	86*	81*	82*
Nongovernment						
New York City <sup>3</sup> .....	68	15,194	77*	77*	66	69
New Jersey.....	63	9,938	73*	73*	65	66
Washington, D. C.....	9	1,818	72*	72*	72*	72*
N. and S. Carolina.....	105	7,121	70	68	69	65
New Orleans.....	7	1,176	75*	79*	79*	76*
San Francisco.....	16	3,178	74	73	70	69
St. Paul.....	9	1,105	68*	68	67	67
Chicago.....	13	2,303	63	65	64	63
Cleveland.....	8	1,830	77	79	73	74
Total <sup>4</sup> .....	298	43,663	72*	73*	69*	69*

<sup>1</sup>Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. Excluding bassinets, usually. <sup>2</sup>General hospitals only. <sup>3</sup>Occupancy totals are unweighted averages. <sup>4</sup>Preliminary report. Complete occupancy figures for January, 1933, to October, 1938, are given on page 798 of The Seventeenth Hospital Yearbook.



## Occupancy Drops Slightly

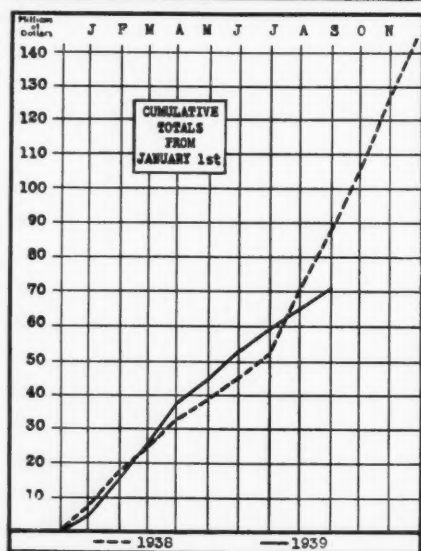
Occupancy in nongovernmental hospitals in August dropped off a point, from 73 to 72 per cent, according to preliminary figures. This is in line with the customary drop in occupancy during the summer months. Governmental hospitals also dropped a point, from 86 to 85 per cent. The most striking difference was in the two New Orleans hospitals in which the combined occupancy fell off 12 points from the record figure of 114.1 established in July. An increase in the bed capacity of Charity Hospital, which reported 1984 available beds in August as against 1735 in July, accounted for most of the drop.

New building projects from August 14 to September 11 totaled \$5,124,554. This figure was somewhat lower than last month's and was a great deal lower than the same period last year.

There was a total of 63 projects begun in this period, with 55 reporting costs. Of these, 13 were new hospitals, the cost for 11 of which amounted to \$577,000. Forty-two of the 48 additions to existing hospitals or to allied institutions reported will cost \$4,513,556; two alteration jobs were started at an estimated cost of \$33,998.

General wholesale prices as reported by the *New York Journal of Com-*

## HOSPITAL CONSTRUCTION



merce jumped 8.6 points, from 73.3 to 81.9 between August 19 and September 16. These figures broken down show that the most spectacular gains were in grain and food prices. Grain prices rose from 53.5 on August 26 to 60.7 on September 7, then to 66.6 on September 9 and, finally, to 69.1 as of September 16. Food prices started to gain during the week between August 19 and 26 when they went from 62.1

to 66.1. They rose to 79.8 by September 9 and then dropped back to 76.5 after the consumer buying hysteria, which began almost as soon as the European War started, ended.

Fuel and textile prices also advanced to a certain extent during the four-week period. Fuel prices started at 57.6 on August 19, dropped to 57.0 on September 2 and then rose to 63.7 on September 9 and 67.1 on September 16, a total gain of 9.5 points. Textiles jumped 4.4 points in the last four weeks, from 80.5 to 84.9. Building material prices have remained practically stationary, fluctuating only 0.6 point during the period under review.

Drugs and fine chemicals, as compiled by *Oil, Paint and Drug Reporter* rose 9.2 from 182.6 on August 28 to 191.8 on September 18.

According to the National Industrial Conference Board, the cost of living of American wage earners, after declining for two consecutive months advanced slightly, i.e. 0.2 per cent from June to July. Increases in costs occurred in each of the major groups of expenditures except clothing. The cost of living in July was 1.8 per cent lower than a year ago; it was 15.4 per cent lower than in July 1929 and 18.4 per cent higher than in the spring of 1933.

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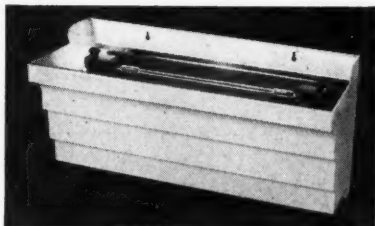
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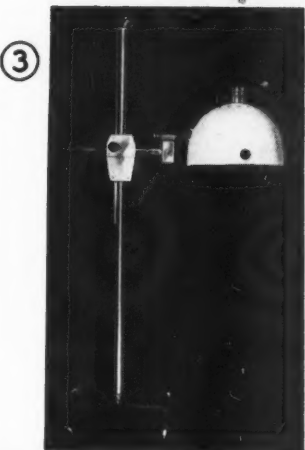
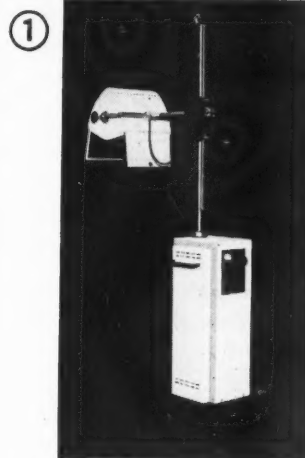
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# WITH THE ROVING REPORTER • • • •

## Family Style

• If you are fortunate enough to be invited to spend the day with Carl Wright Jr., superintendent, United Hospital, Port Chester, N. Y., you had better see that your pencil point is sharpened and you have plenty of note paper handy. You will need them, particularly when at lunch time you sit at the round table in the dining room where the heads of the hospital family gather each noon. Taking a leaf from the Book of Business, which tells us that the successful business man closes more deals over the luncheon table than at any other place or hour, Mr. Wright holds an informal staff meeting each noon. The chances are that you will be introduced to such department heads as the supervisor of nurses, admitting officer, accountant, housekeeper, dietitian and social service worker. The conversation may start with politics, but it invariably ends with a discussion of hospital problems as related to the various departments represented.

Somehow the complaint of one department against another seems less significant in the course of a good lunch, with a cup of steaming hot coffee in front of you, than it would in the formal surroundings of the executive's office. Nurses are late getting to their stations in the morning because of what they declare is delay in the dining room. What has the dietitian to say about it? Wait until the admitting officer passes her the cream for her coffee. "Thanks, now if the girls would only—"

Should it take quite so long to clean private rooms and get them ready for the next patient? How might this work be speeded? But by this time it's dessert and between bites of juicy apple pie the housekeeper explains her problems.

There is nothing formal about these meetings. Quite the contrary, their extreme informality is the chief reason for their success. "The most profitable hour of the day, one that everybody looks forward to with keen anticipation." They all say the same.

## Why Not Health Talks?

• Health talks for the benefit of the general public sponsored by the hospital are growing in popularity each year. It is interesting to note that one of the pioneers in this movement is the Mount Sinai Hospital in Philadelphia. Each winter season for seven consecutive years this hospital has conducted with great success a series of lectures on personal health.

Recently your Roving Reporter was

reminded that those hospitals that have never experimented with public health talks might be tempted to do so beginning this fall. For this reason, he will outline the talks presented in the conference hall of Mount Sinai during the second half of last season.

The first comprised a timely discussion of winter health problems entitled "Don'ts in Ear, Nose and Throat Conditions." Then there was a summary of the latest developments for combating that mysterious malady known as rheumatism. Third on the schedule was a frank discussion of syphilis, while the fourth and last of the series was "Old and New Ideas of Childbirth," including interesting revelations regarding old superstitions and new treatment.

When it is possible to do so, medical motion pictures are used to illustrate the talks and to lend added interest to the presentation. Questions, too, are welcome at the close of each lecture. Plenty of publicity is given these events. The public relations department of the hospital maintains a lecture mailing list, consisting of the names of all those individuals who express interest in receiving notification regarding subject matter and dates.

## "It's a Fact"

• Speaking of Mount Sinai, the hospital distributes an unusually entertaining little quarterly magazine, full of arresting items regarding the work that is being carried on. In a recent issue, for example, under the eye compelling title, "It's a Fact," the editor proceeds to enlighten the patient on the question of food that is served him.

"Once you are a hospital patient, a meal ceases to be a meal and becomes a part of your treatment. Your doctor orders light, soft, liquid or house-diet. Or he may prescribe a salt-free or diabetic diet, or one of many other types.

"The rate of your recovery will be affected by the accuracy with which the dietitian follows your doctor's orders.

"No ordinary chef could do what the dietitian must do for you. So, while your meals in the hospital may not be as elaborate or as tasty as in a restaurant, more skill goes into their preparation. Incidentally, if your condition is such that the doctor orders no food, or very limited quantities, you are not an inexpensive patient. It is a fact that the less food you are permitted, the greater the amount of other service you require."

## Some Questions Answered

• Every now and then the question is raised as to whether or not it pays the hospital located in a rural community to raise its own foodstuffs. And what about bread? Does it pay the hospital to bake its own bread?

Let us examine the books at St. Mary's, Pierre, S. D., a hospital of 102 beds. Better still, suppose we ask George Kienholz of the South Dakota State Hospital Association to answer these questions for us. First, it should be explained that the hospital operates a dairy farm and extensive vegetable gardens. Mr. Kienholz tells us that in a recent year the market value of milk and meat produced on the farm totaled \$3,312.96. As against this, the market value of the feed used was \$2,070, making a profit of \$1,242.96.

During the same period, the hospital poultry farm produced \$586.68 worth of eggs and chickens. Again the value of the feed was \$230, bringing the profit to \$356.68. Foodstuffs grown in the garden were valued at \$391.15 with a seed cost of \$35, showing a profit of \$356.15. While labor is not included in these figures, there is still a considerable saving.

Answering the final question about bread, Mr. Kienholz estimates the weekly cost of bread ingredients at \$7.16, and the market value of the bread and rolls turned out at \$49.74, a profit of \$41.58.

## How About "Social Rounds"?

• Before we leave Pierre and journey on to the next stop, Mr. Kienholz has a question to ask.

"Do you, as administrators, ever take time out of a busy day to make rounds? I don't mean collection rounds or grievance rounds; I mean social rounds. The patients rightfully expect the staff to make rounds, whether they need any professional attention or not. Social rounds are something extra—and how they do appreciate it, especially those with little or no contact with their home folks. Adjust the window shade; turn that pretty flower around so they can see it; pick up that letter that is ready to be mailed and post it. Tears of pain can be lessened and tears of homesickness entirely wiped away. It is so simple, and takes so little time. This may sound like kindergarten stuff, but we have been graduated from the kindergarten class so many years ago that a review of the things that we learned there is sometimes not amiss."

# LOOKING FORWARD

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## Preparedness Program

HOSPITALS in the United States, unlike those of Europe, are not faced by the necessity for planning air raid precautions. They may never have to go to that extreme of preparedness. Nevertheless, certain measures they must immediately take in view of the unpredictability of the course of the present war. Doctor MacEachern, in an article in this issue, urges that "thought and energy and well-directed teamwork" be employed to "plan the utilization of the vast personal and material resources that have been built up through the years and to supplement these with whatever may be needed further in case we might become involved in the conflict."

Preparedness is, indeed, as much the duty of the forces devoted to healing as it is of those that may be needed to stay with arms an enemy's advance. It is as imperative that our President be assured that the hospital profession is mobilizing as that the Army, Navy and Marines will be ready when the time comes, if come it must. The best way to prevent such an eventuality is to demonstrate complete preparedness as quickly as we possibly can, because in a war mad world the only effective deterrent against acts of war is display of superior strength.

In many respects the hospitals of the United States are ready for an intensive preparedness program. Doctor MacEachern relates how advantageous for such a purpose are the organizations in the hospital field through which mobilization could be effected and how much better situated we are than in 1916 with regard to knowledge of our exact resources, where they are, how good they are and what sources exist through which they can be replenished and supplemented. He mentions *The HOSPITAL YEARBOOK* as an invaluable aid, nonexistent in 1916. He emphasizes the advances in procedures, technic and in the general functioning of hospitals. These have been achieved through determined, continuous effort, in which hospital standardization has been a prominent stimulating factor.

Careful analysis of the situation today seems to indicate that what is needed to achieve greater prepared-

ness is chiefly more pressure on the things we have been emphasizing right along—unification, organization, training, improved procedures and equipment, all that is involved in assumption of constantly growing responsibilities for the preservation and restoration of health in our communities and in the nation.

Preparedness for a war that we pray may be averted will not represent wasted funds and effort if the worst that we fear never happens. No resources that we may accumulate, no personnel that we may train and mobilize can ever be too great or too well correlated to divert to peacetime uses. The stimulus of preparing for possible war service will carry the hospitals of the United States forward.

## "Mother and Baby Doing Well"

THE foregoing words have a familiar ring to hospital workers. To anxious fathers and relatives they represent glad tidings. Too often, however, this double assurance must be qualified.

Why should not mother and baby routinely stand their ordeal successfully? In some instances morbidity and even mortality enter the picture apparently unavoidably. But far too often complications arise because someone failed to do his or her duty. Sometimes it is the patient who fails to heed the physician's advice, although the doctor cannot always be wholly exonerated. In some hospitals ward maternity patients are more closely supervised than those occupying private rooms.

Some competent observers believe that there is more unnecessary and meddlesome interference with the natural course of pregnancy in the private than in the ward patient. The uncomplicated and relatively safe delivery of patients at home has been pointed out to substantiate this statement. Private patients are often not given Wassermann tests for several obvious reasons. In large courtesy staffs, prenatal measurements and frequent examinations for the detection of signs of the development of toxemia are often neglected for long periods of time.

The delivery should be but the culmination of months

of observation and study. Natural forces alone are often capable of completing this stage of pregnancy. Of the greatest importance is the service rendered the patient and her baby long before hospital admission is necessary. No hospital should conduct a maternity department that believes that its expected service can be encompassed merely by the usual fortnightly stay of the patient in the institution.

## Some Infectious Diseases

**T**HERE are many reasons for the rejection of applicants for admission to the wards, depending on the patient concerned and the quality of the traditions and policies of the hospital. In the study of rejected applicants, which every hospital should make periodically if it does not wish to keep its head in the sand, some reasons, such as "lack of room," will be obvious while others, such as "infectious disease," will be doubtful. Every hospital should be in a strong moral position to justify its rejections. "Lack of room" and "lack of funds" are acceptable, provided they are genuine and beyond immediate help. A slavish conformity with precedent that excludes certain communicable diseases because our grandfathers, with their limited knowledge of infection and immunity, found this to be desirable, is, however, inexcusable.

Consider, for example, the case of pulmonary tuberculosis which, apart from its tendency toward chronicity and its low comparative contribution to the cost of maintenance, we have feared more for its ubiquity than for its contagiousness, and more for esthetic than for clinical reasons. We are taught now that such patients may safely be admitted to general wards provided certain elementary rules of cleanliness, which should prevail in any case, are observed. One important school does, in fact, hold that active cases of pulmonary tuberculosis do better in general hospitals than in tuberculosis institutions, because every diagnostic and therapeutic facility for their care is immediately available in the general hospital. Pulmonary tuberculosis is now being treated actively rather than passively, and the surgeons appear to be stealing a march on time with their successful attack on pulmonary cavities.

The same holds true for the venereal diseases, a subject that is even more distasteful to the hospital administrator, as well as to every other citizen in the community. As in the case of pulmonary tuberculosis, the best facilities should be made available for the prompt cure of venereal disease patients. These two great categories of infectious disease should appear prominently on the agenda of the hospital conference these days. Furthermore, thorough physical examination of employees on appointment and periodically thereafter may well be considered simultaneously in this campaign of cooperation with the field of preventive medicine. Chest x-rays for employees have not yet

come into general vogue, though they are relatively inexpensive.

If we are now reliably informed that hospitals need no longer refuse admission to patients because they suffer from these communicable diseases, is it not time for us to redraw the line? At what point does an individual patient become a menace to others in the same ward, either by the uncontrollable spread of his infection or by the absorption of too large a proportion of the hospital budget for his care? There are apparently many opportunities left for hospitals to cooperate substantially with the public health program of this country, in addition to the valuable work done by them in the other fields of educational investigative and curative medicine.

## No Apology Due

**H**OSPITAL care is an expanding term. It must continue to expand if our service is to keep abreast of the advances of medical science and practice.

A few years ago the expenditures by hospitals for pneumonia serums and blood for transfusion were negligible; today they are considerable. Oxygen therapy formerly was used only in desperate cases as a last resort; today it is used early and, in some instances, as a preventive. Many nurses now active can remember the time when it was not unusual for a single nurse to be left in charge of from 50 to 75 patients at night; today 20 or 25 patients are usually considered a reasonable load. The number of radiologic and clinical examinations per patient has soared during the past few years. Intravenous therapy only a few years ago was exceptional; today it is almost routine in many conditions.

All these medications and procedures, which have largely replaced the inexpensive pills, tinctures and elixirs of the past, cost money. They help to boost the cost per day of hospital service. But does that mean that we should apologize for them? Are we to feel on the defensive because we have saved a life with oxygen, because we have cured a pneumonia patient with serum or because we have materially shortened the patient's stay with proper postoperative therapy?

These are causes for pride in our work, not for condemnation and regret. Even though we are forced to charge more, the improved service is a better bargain for our patients than the service we used to give at lower rates.

The problems presented by rising costs face all progressive hospitals and all hospital service plans. Let us make every economy that is possible through sound and expert administrative control and cooperative community action. Having done this, let us see our rates at a fair figure in view of our costs.

Finally, let us stop apologizing for hospital costs. Instead, both hospitals and hospital care insurance plans should capitalize upon the fact that the increased rates reflect the tremendous improvements that have taken place in all branches of hospital service and the wider public demand for this improved service.

## Standing Problems

AT THE Senate hearings on the Wagner Health bill, the vigorous criticisms expressed by hospital people were chiefly based on the bill's failure to recognize the voluntary hospital properly. Senator Wagner and members of the Senate committee conducting the hearings gave assurance that it was their intention to do so, but the fact remains that the bill was unsatisfactory to the hospital world in this respect and was indefinite concerning other issues on which clarification should be sought. In a preliminary report submitted by the chairman of the Senate committee, there are promises that the bill will be amended and reappear next year in a more acceptable form.

Postponing action on this bill, however, does not remove existing problems currently faced by hospitals. There are at least six long-range issues remaining on hospital doorsteps.

There is a comparatively large number of vacant beds in voluntary hospitals as a group.

There are many communities and areas that have no hospitals; others have only proprietary hospitals. In many areas the voluntary hospitals can support but few beds for free patients.

The present use of state and local tax funds to meet these needs must be extended.

Voluntary as well as governmental facilities must be utilized in any scheme of expanding general service.

Many states and localities are unable to deal financially with their needs without federal participation.

A demand for public action has appeared from consumer organizations that are important enough to make it likely that they will receive attention from Congress and from many state legislatures.

Hospitals themselves are keenly conscious of the vacant beds that they would like to fill with patients who need their services. Those who have given attention to conditions in poorer states and in many rural areas even in other states know that there are existing deficiencies in hospital facilities the exact amount of which must be determined through impartial surveys. The necessity of federal participation in some degree is questioned by hardly anyone, the keen debate being upon how far it should go and how such participation should be administered.

Voluntary hospitals are now utilizing for the care of needy patients at least as much money from state and local tax funds as they are receiving in gifts from individuals and organizations. Many local hospital bodies

are now seeking more tax support. The governments and the hospitals must be partners and not antagonists.

It is important that hospital people and hospital associations face all these issues squarely, with an eye to facts rather than to feelings. It is important that we pursue policies that are determined by the standards and needs of hospitals themselves, avoiding political and emotional issues. Under a democratic system of government, hospitals are dependent upon the sympathetic understanding of the public.

## William James Mayo

APPROXIMATELY two months after the death of his younger brother, Charles, Dr. William James Mayo died in Rochester, Minn., on July 28. In the course of his life he was awarded a large share of the honors that medical organizations of the United States and of other nations have it in their power to bestow. In addition, he was the recipient of several decorations and of many honorary academic degrees. Doctor Mayo began the practice of medicine in 1883; rapidly he became a master surgeon and subsequently a prominent figure in postgraduate medical education. Humanitarian that he was, his interest early became engaged by hospitals and their problems.

Practical, charitable and, elsewhere in his address, taking his stand as defender of both hospital and physician against the exploiter, Doctor Mayo spoke as follows when he was president of the American Medical Association, in 1906: "Our first object must be to see that no poor person shall be subjected to the slightest inconvenience or annoyance and that every worthy charity shall have our united support." Five years later, at the University of Minnesota, he declared: "The University State Hospital has come to stay. . . . Enlightened socialism is the keynote of modern civilization." It is noteworthy that this was said in 1911.

In the 1920's he wrote several articles and speeches. Among them was an address given at the opening of the Thorndike Memorial Laboratory in Boston and the following is taken from that address: "The municipal hospital is closely related to the social and economic life of the people. The very necessity for such an institution is an admission of failure properly to adjust the individual to the community as a whole."

In a short paper printed in 1930, Doctor Mayo wrote: "In the new hospitals that are to be built, I look forward to seeing far-reaching changes in planning, construction and business management that will give sick people in moderate circumstances privacy and good care within a price that they can afford."

Thus, in relation to hospital problems, it has been possible hastily to review a few isolated pieces of documentary evidence of that social consciousness out of which grew, perhaps, the entire life structure, and certainly the greatness, of William James Mayo.



# At Home in a Texas Hospital

RAYMOND P. SLOAN

AS YOU look at Paris on the map of Texas, there is nothing to differentiate it from many other communities in this vast state of amazing productivity. Travel across the cotton fields from Dallas, if you will, and there it is lying before you in the northeastern section of the state, just 16 miles from the Oklahoma border. Paris is a thriving, modern city of approximately 22,000, made beautiful by Nature's bounteous gifts of warm sunshine and fertile soil.

Even closer acquaintance fails to reveal marked difference between Paris and other towns encountered through the state. Yet in the very heart of the community lies a marked difference, an indescribable something that invites reflection. The happy smile on the face of that mother, for example, as she stands there holding in her arms a small child whose head is swathed in bandaging! A simple question addressed to her provides the first clue.

"Could you direct me to the Sanitarium of Paris?"

The pedestrian's dark eyes brighten with interest. "Follow me," she replies with true Texan hospitality. "I am going there, too. It's just a few steps."

We enter a beautiful garden, beneath the cool shade of spreading trees. Around us great clumps of ornamental grasses sway gracefully

in the autumn breeze. Benches here and there are occupied by men and women who talk quietly. Over in the corner by a pool nestled in a rock garden, a young woman is embroidering. Below her is a picnic ground with stone benches and tables.

"Indiana Park," our guide ex-

plains, and adds, "over there is Kentucky Cosy Corner."

"But the hospital. I am looking for the hospital."

"This is the hospital. You see that building standing by itself over there; that's Griffiths Memorial for Children. My boy was operated on there last week. Straight ahead is the main building. Doctor McCuiston has his office there. You are here to see Doctor McCuiston? I'll show you the way."

Eyes shining, she proceeds along a garden path lined with flowers up to the entrance of a—no, not a hospital in the usual sense of the term, but a "home" for those who are ill and in need of proper care.

That is why Paris is Paris and not just another Texan city. It boasts a modern hospital surrounded by gardens that the public uses as its own. It boasts a hospital reflecting a spirit of friendliness, of genuine interest in the individual, of desire to serve, that has won it the loyal support of the entire community; a "home" to which all may turn when illness threatens.

Before entering, let us rest for a minute on the doorstep and try to visualize what has brought this about. Let us look back twenty-five or even fifty years. It will enable us to appreciate better what lies within.



Top, left: The picnic grounds complete with outdoor fireplace. Top, right: A pool and rock garden make "Indiana Park" a pleasant place for patients, visitors and the staff. Above: The north entrance to George A. Griffiths Memorial Hospital for Children.

It is a dream come true, the dream of a 19 year old boy who had just received his diploma from the Kentucky School of Medicine. Even back in those early days, Dr. L. P. McCuiston envisioned what he hoped would one day become a community hospital in the true sense of the word. The first step was taken in 1910 with the purchase of an old mansion in the center of a wooded tract occupying about half a city block. Next, in 1912, came the organization of a corporation comprising a group of public spirited citizens whose ambition it was to render more extensive service to the sick throughout that area. The old house was remodeled to accommodate the nursing staff and the hospital was erected to the north in front of the home and connected with it by an arcade. It opened in 1914.

Its growth has been steady. Additional property has been purchased and new wings have been added; in 1936 a gift made possible a separate building for children's work. This building is known as the George A. Griffiths Memorial Hospital for Children. Today the sanitarium has 62 beds and 7 bassinets in its main building, while the Children's Hospital has a bed capacity of 10.

Within the Sanitarium of Paris is every facility of modern medical and surgical practice. There are an x-ray department equipped for radiography, fluoroscopy and therapy; a clinical and pathological laboratory; a surgery, a urological department and a separate maternity unit. It is not these familiar features of the general hospital, however, that engage the visitor's attention as much as it is the auxiliary departments by which

the sanitarium has made a place for itself in the life of the community.

Those people seated in a comfortable room to the right of the main entrance are not there to see relatives and friends in the hospitals. They are patients themselves, waiting to see the doctors who have their offices in the building. Five physicians on the staff are provided with offices in the main building and two others have offices in the Children's Hospital. All work together, receiving their patients at the sanitarium and using its facilities in their treatments.

Also, in this same building is the hospital library, a large room lined

from floor to ceiling with book shelves. But it is not a hospital library as we generally find it. The L. P. McCuiston Library is available to hospital patients, employees and the general public. It was started in 1923 with the appointment of a committee and the sum of \$100 to organize a library from books that had been donated and that might be augmented by purchased editions. At the end of the first year 817 books were listed.

Two years later, as a tribute to Doctor McCuiston, \$15,000 was donated for the founding of the L. P. McCuiston Library. This was not established, however, until 1930, owing to lack of space. In that year the present library was built as part of an annex, affording ample space for fiction shelves, reading room, stacks and repair room. A full-time librarian is now in charge, and the number of volumes totals more than ten times that of 1923.

The library is in reality a social center, filling an important niche in both the hospital and community life. The reading room is furnished with metal tables, files, charging desk and adjustable shelves to care for 12,000 volumes. Windsor chairs are placed at the reading tables and easy chairs in soft leather are provided for convalescent readers. The walls are tinted in soft green and rose; the floors are rubber tile. Monk's cloth curtains and bright colored hangings add to the cheerfulness of the room.

Patients are supplied with reading matter at no charge and are not fined for books that are overdue. Each day the librarian makes her rounds and offers suggestions for reading material. The youngsters are intrigued by



Above: "The Acrobats." Nurses entertain themselves and their guests at a Halloween circus. Below, left: A corner of the nurses' library and reading room. Below, right: Two nurses admire Polyantha roses in the rose circle and a stone rabbit admires them.



the toys, dolls and puzzles she brings, and the men's ward was kept engrossed for a week in the construction of model airplanes.

The library is open to the public each day from 10:30 until noon and again in the afternoon from 4 o'clock to 5:30. It keeps lists of required reading for its town students as well as the yearbooks of various clubs and recommended plays for the Little Theater, working in conjunction with the public library. Its reading room numbers among its members teachers, students, club women and others who enjoy browsing. Outside membership costs \$5 yearly. Employees and patients have free access to the room, as have ministers of the city and certain charter members.

Each year, too, the library sponsors some type of entertainment. Free lectures, book reviews and other events of an educational nature attract wide community interest. Most important is the fact that it tends to disassociate the hospital from pain and suffering and introduces an atmosphere that is helpful and stimulating to patients and hospital workers alike.

Continuing through the annex, we find the headquarters of the training school, for the Paris Training School for Nurses antedates the Sanitarium of Paris. During the years it has filled a real need among girls of Paris and the surrounding community who wish to get a degree without being obliged to live in a large city. The school has 40 students at present. A full-time instructor is provided and the educational unit includes a large classroom, approved demonstration room, nurses' library and offices for the superintendent of nurses and the instructor. The classroom can be converted into a general assembly hall. Three courses of instruction, dietetics, psychology and chemistry, are taught by Paris Junior College instructors; other courses are given by the instructor and by staff doctors in the afternoons.

Out again into the bright sunshine of the hospital grounds! It becomes evident that hospital activities are carried on in numerous buildings, in addition to the Children's Hospital. Incidentally, this thoroughly modern unit has eight private rooms and one semiprivate room, including quar-

antine on the lower floor, diet kitchens and surgery. Out-patient departments are provided for both white and colored patients.

Other buildings include three homes for the personnel. One houses the night nurses; another, the day student nurses, and the third provides accommodations for the nurses of the Children's Hospital. This also is used for recreational purposes, which means that it is a busy place, indeed, for Margaret Kennedy, the

it does not entail a loss, and it does enrich and give variety to the menus of patients and personnel. It is in charge of a manager who shares with two regular helpers the responsibility for a truck farm, an orchard, berry patches, dairy, poultry and a piggery. As Miss Kennedy puts it, "No little satisfaction comes from serving country-made butter and buttermilk. Then there is the necessary supply of cream, whole milk and separated milk for cottage



Above: The children's hospital looks more like an attractive home. Right: A corner of one of the medical staff offices.



superintendent, and her staff believe that all work and no play makes Jack, or rather Jill, a dull girl. Likely as not, therefore, on a Saturday evening or when holidays roll around, shrieks of laughter can be heard from this building indicating that a party is in progress. Sometimes, too, these events take place outside in the Kentucky Cosy Corner or Indiana Park for the benefit of visitors.

Another building that holds much interest is the cannery. But, first, mention should be made of the hospital's farm, a 30 acre tract situated about a mile beyond the city limits. This is operated "not for profit," yet

cheese, all of which form a large part of the dietary requirements." The dairy herd averages about 40 cows and 18 calves.

Another important service is fattening baby beeves and Hampshire creep-fed lambs. The raising of hogs has been found well worth while for the consumption of waste products from the kitchen. "In return," Miss Kennedy states, "there are lard, ham and other pork products, so popular with the nurses and hospital family. Patients, too, like country style meals occasionally."

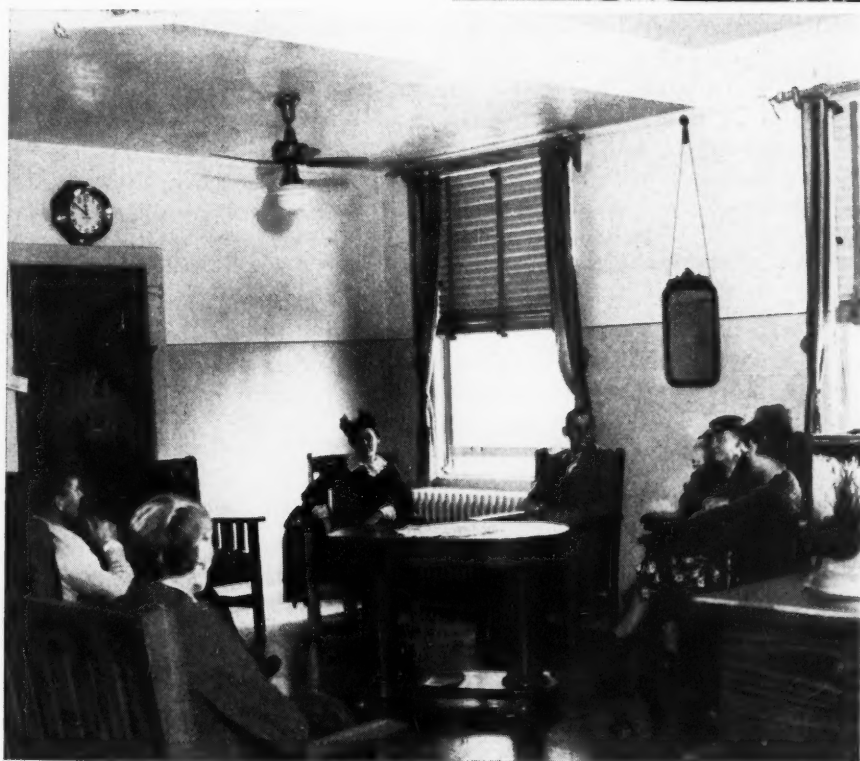
The maintenance of the farm makes it necessary to provide for canning various foodstuffs. This problem was solved by transforming an old garage on the hospital grounds into a modern cannery. Two well-lighted rooms are available, with concrete floors, shelves for jars and cooking utensils, gas stoves, tables, chairs and sinks. One room is equipped for the preparation of fruits and vegetables for canning; the other, for the actual work of preserving these products. Steam pressure cookers assure the high pressure used in commercial canning. This has proved

economical, despite the fact that it requires an extra shift of workers.

Farm products are also taken on account, and the cannery has provided work for unemployed women. Both the cook-in-the-kettle and the cook-in-the-can methods are used. Use of the tin can is preferred to the glass jar because there are less danger of breakage and less loss by spoilage; also less time is required in processing. Machines are used for sealing



Right: A corner of the memorial library. Below: A group of patients waiting to see the doctor.



the filled cans and for reflagging used cans that have been properly opened. Above the cannery is the resident physician's apartment.

Back in the garden we sit beneath one of the great trees and ponder. The dreams of a young doctor many years ago have come true. Loyalty, labor and love have developed a real community hospital. Changes in the personnel of the Paris Sanitarium have been surprisingly few. Turn-over in labor is almost negligible: twenty-five years for Miss Richey, secretary to Doctor McCuiston; eighteen years for Mr. Haley, manager of the farm; sixteen for Doctor Hammond, radiologist; sixteen for Mrs. Drummond, technician; twelve for William Mosely, the yard man. Agnes Hogg, superintendent of nurses, has filled her position without interruption since the origin of the training school in 1911. Miss Kennedy has been associated with the institution for nineteen years, and the loss of Elizabeth Hilf, the former superintendent, was so mourned that "as a salute in honor of her memory" the position made vacant by her death was left officially unfilled for one year.

Loyalty, labor, love—the same attributes have characterized the board of directors during the years. Eleven men, two of them doctors and the rest prominent in the business life of the city, carry on, and despite many changes the same spirit prevails as that which prompted the founding of the hospital. In paying them tribute, Doctor McCuiston remarked: "It is noteworthy that during the twenty-five years of the institution's existence the board of directors that has so wisely guided and controlled its affairs, fashioned its policies and directed its activities has always been in perfect accord and that, during all of its administrative sessions, there has never been a dissenting voice. Its agreements have ever been uniform, ready and without scruple."

The hospital gardens are now empty. Lights begin to show in the windows. From Griffiths Memorial comes the faint cry of a child. The soft air of fast approaching Texan twilight brings with it, too, the happy voices of young people.

A dream come true in Paris.

# WAR in Europe!

MALCOLM T. MacEACHERN, M.D.

THE United States, with its millions of people, its unlimited resources of all kinds, its culture and its high standard of civilization, rightfully wants to keep out of the war that rages in Europe. In the minds of many of the people today there still linger the memories of the Great War of 1914 to 1918. Even at this day, a quarter of a century later, we see thousands of wounded veterans still in veterans' hospitals, under the watchful care of medical science. What a tragedy was that war! What a tragedy, yet to be enacted and written, the story of this war may hold!

With the world shaken as it is today, with armies guarding every frontier in Europe, and with bombs, shells and torpedoes wreaking destruction on land and sea, we are forced to recognize our need in the United States for preparedness.

## What the World War Taught

Preparedness, however, is not alone a matter of mustering fighting man power and of collecting the materials of war. It includes also the mobilization of those who are to care for the wounded and the reckoning of the resources that are to aid them in obtaining maximum rehabilitation of the casualties of war. Hospital administrators are among the first people who must adopt preparedness as their watchword. Hospitals and their equipment are among the resources that must be brought to maximum serviceability in the preparedness program.

Lest the future look too dark, it should be recognized that advances in the destructive power of the implements of war have been offset in some degree—we hope to a very great degree—by advances in the salvaging power of modern scientific medicine and surgery. The World War taught the surgeon a great deal that he did not know before, since it forced exploratory groping for deeply embedded bullets, in the course of which new surgical techniques were developed that have been

widely applied, especially when operative procedures on the head and on thoracic areas were indicated.

Concomitant with the introduction of these new technics was the development of better methods of controlling wound infections and these also have since been employed in surgery that had no connection with the battlefield. The war experience also gave surgeons better ideas of how to manage fractures, so that the percentage of complete or nearly complete restoration of normal functioning is now many times higher than formerly.

The modern hospital, too, and all its appurtenances are strides ahead of the hospital of the early 1900's. Science and invention have found in it enticing fields for labor and have produced some imposing wonders that challenge their exploits in munitions factories and airplane manufacturing plants. Some of the brains and the ingenuity of mankind, fortunately, are being devoted to saving life to balance the efforts being put forth to destroy it.

## Hospital Organization Improved

Organization is another phase of preparedness that has been wonderfully developed in the medical and hospital fields since the war. The hospitals of the United States, particularly, offer to the nation a solid, unified front instantly ready to operate at maximum efficiency should an emergency arise. Hospitals, by the very nature of their service, operate with eyes open to all possible emergencies. What their administrators and other key personnel need to do now is merely to look farther away for an emergency for which they may prepare, though they earnestly hope it may never materialize.

The hospitals of the United States and their personnel are already mobilized in the active, well-managed organizations with which governmental agencies cooperate. Marvelously organized are the Army, Navy, Public Health Service, United States veterans' hospitals and other governmental facilities, with which the American College of Surgeons has worked for several years and which are not only meeting the minimum standard of the college, but are far exceeding the letter of the law and approach a maximum standard. Around this nucleus, in case of a national emergency, could readily be gathered the full facilities and resources of the voluntary hospitals of this country to form a smoothly functioning unit for reclaiming the wounded.

## Resources of Organized Data

The people of this country should find comfort in the thought that preparedness really exists in hospital and medical work today, to a degree that makes the conditions in 1916 look like total unpreparedness. There now exists an accurate inventory of the personnel power and facilities of all of our 6166 registered hospitals in the United States and her possessions and protectorates. This has been accomplished by the great national organizations, such as the American Hospital Association, American College of Surgeons, the American Medical Association and others.

The American Medical Association has provided an extensive registry of hospitals during the past several years. The American College of Surgeons has in its files approximately 50,000 reports of surveys of hospitals of 25 beds and over which it has conducted for the last twenty-

# Hospitals of the United States Are Ready

# PREPAREDNESS in America

Associate Director  
American College of Surgeons

two years, thus affording complete and accurate information pertaining to every type of service and every kind of trained personnel in these institutions.

The American Hospital Association has collected invaluable data since its inception and in its files is readily available a variety of information of value for emergency purposes. One use that comes to mind for some of these data would be in organizing hospital units. No difficulty would be encountered in organizing and putting into action on short notice 50 or more hospital units for the care of casualties in case of war, simply because it could be quickly determined from the records just where and how to get the personnel and equipment.

## Human Resources

More than 800,000 persons trained in the procedures directly and indirectly concerned with the care of the sick and injured are employed in the hospitals of this country. Among our administrators of hospitals are some of the outstanding leaders in the world, men and women of unexcelled organizing and managing ability. Some 90,000 of the 120,000 registered physicians in this country are working in hospitals; among them are many hundreds of specialists in every possible field of medicine and surgery. These are the human resources the United States has that can be commandeered without delay to minimize the toll of life and limb and to relieve suffering.

To the foregoing resources, for use in the same service, should be added another three quarters of a million people who are engaged in health promotion and disease prevention efforts outside of institutions and from

whom additional aid can be quickly obtained for patriotic service at home or abroad if required.

Preparation of newly trained personnel to keep the ranks of nurses, doctors, technicians, administrators and other skilled workers filled and to supplement the army if need be goes steadily on to the accompaniment of ever rising standards. In our training schools for nurses are some 80,000 students, which means that more than 20,000 graduate nurses enter service each year. In the country today are more than 200,000 highly trained graduate nurses. Our medical schools graduate from 5000 to 6000 doctors a year. Intensification of training is indicated as an important part of a preparedness program.

Since the World War surgery has been extended and improved. Neurosurgery (and what is spoken of as head surgery, for example) is virtually a new specialty, being an outgrowth of the late war. Now we have many well-qualified neurosurgeons as well as general surgeons who are most capable of handling head injuries. Every sizable community has at least one thoracic surgeon capable of handling the traumatic chest and other conditions within the thoracic wall with early or late complications. Traumatic surgery has developed. Since 1928, the American College of Surgeons has surveyed the major industries of the country and has developed a minimum standard for medical services, which has been adopted by the leading industrial organizations. Some of the most competent surgeons in caring for traumas of all kinds will be found today in industry.

The American College of Surgeons has also built upon the war

experience of surgeons in the treatment of fractures. Through an international committee of outstanding surgeons, marvels have been accomplished in improving procedures in this field. Sixty-six regional groups throughout the United States having a total membership of 1200 surgeons who have given special study to all phases of fracture work—emergency treatment, transportation, technical procedures and medical education—disseminate to the profession and to the public information designed to further good management of fractures. Standards have been set up, proper procedures have been put into operation and equipment has been perfected, so that in case of war vastly better results may be expected.

## Resources of Equipment

Rapid advances have been made in every branch of medicine so that physicians and medical specialists are better able than before to cope with battlefield conditions. Aiding the physicians and surgeons will be much more efficient medical, surgical and hospital equipment, instruments and supplies. These are all well standardized and of excellent quality and the supply is ample. Beds, sterilizers, operating room lights, instruments of all kinds, apparatus for bone surgery and other work, facilities for treatment of shock, hemorrhage and similar conditions have advanced greatly in design and in quality.

The mobilization of manufacturers of medical, surgical and hospital equipment and supplies on a war-time basis could readily be accomplished if such a need arises. Never before in this country has there been such potential strength for the production of hospital equipment, apparatus and supplies as exists at present. Never before have these

## for an Intensive Preparedness Program

industries attained such a standard of efficiency in production.

The need for being better prepared from an equipment standpoint for future emergencies was felt by the president of The Modern Hospital Publishing Company after the World War. He conceived the idea of The HOSPITAL YEARBOOK to provide reliable, properly classified listings of dependable medical, surgical and hospital equipment and supplies. This volume, published annually, contains also a check list of equipment for various departments of hospitals, as well as specifications for many of the articles listed. At least two of the countries now at war have already obtained copies of this

book. This is concrete evidence that we are better prepared, should war overtake us, than we were when we entered in 1916.

No group in this country could or should be more opposed to war than hospitals and doctors. Like floods, tornadoes, earthquakes and other catastrophes, war brings grim duties that tax their spirit and endurance. But, dedicated as they are to the relief of suffering, they must wage a war of their own on all causes of suffering. Although war itself is abhorrent to them, they must be prepared to cope with its consequences should it come.

While I have emphasized how great are hospital resources and how

comparatively well hospitals are prepared, I would not leave the impression that complete preparedness exists. Thought and energy and well-directed teamwork are urgently needed for the most effective utilization of the vast personal and material resources that have been built up through the years and to supplement these with whatever may be needed in case we become involved in the conflict. We must be entirely ready to oppose the forces of destruction with the forces of life saving, although we hope that the need will be limited to the help that can be rendered in relieving the inevitable and lamentable suffering of victims of war other than our own countrymen.

## Tour of German Army Hospitals

NO COUNTRY in the world has a system of military hospitals more modern and efficient than Germany's. All the army hospitals of the Reich have been built since 1933 and they are believed to have attained a total capacity of 20,000 beds.

According to Hans Hermann Klaje of Berlin, in command of these institutions, the new army hospitals have been distributed in accordance with a plan covering the whole length and breadth of the German empire. They are built as units in a complete scheme. All are situated within convenient reach of several garrisons and are graduated in size according to military necessities.

The German army hospitals are built in sizes of 100, 200, 250, 300, 400 and, rarely, 500 beds. Larger hospitals are not built for army use both because they are difficult to supervise and because they would be vulnerable during air raids. The buildings are kept low, usually two stories only, so that they cannot so readily be spotted from the air. The tallest of these buildings is only five stories high.

Most of these hospitals are located on the outskirts of a town in a fairly sheltered district.

The square footage per bed is extremely generous for the reason that the army hospital is also a convalescent home (in peace times, at least), for the soldier is kept in hospital until he is able to take up service again.

All patients' rooms in these hospitals face south or southeast in accordance with Central European climatic conditions. Some rooms facing north or east are provided for cases of high fever. On the ground floor in front of the wards there is usually a terrace 16 feet wide and each of the upper stories has a balcony 5½ feet wide, which is accessible from the ward.

In all the hospitals there is a sharp division between septic and aseptic operating rooms. Air conditioning is not commonly provided the surgery.

In these institutions the sterilizing equipment and the pharmacy are large out of all proportion to the bed capacity. These departments supply the troops as well as the inpatients with bandages and medicines.

Particular emphasis is given to physical therapy. All the army hospitals have an extensive baths department with various kinds of therapeutic baths—douches, steam, colonic

irrigation, underwater intestinal, sulphur, underwater massage; also movement baths, mud baths, saline baths and the like. There is extensive equipment for electrotherapy.

One army hospital for every army corps is equipped with a pathologic, bacteriologic and chemical research department.

These hospitals are outstanding not only in their technic, according to Herr Klaje, but in the effort that has been made to harmonize hospital technic and architecture. Furthermore, the buildings are given an artistic outward form that is in keeping with the architecture of the town in which they are placed.

An explanation of the newness of the entire construction program in the army hospitals of Germany is that, after the World War, Germany's army was limited by the peace terms, and construction of military hospitals was not allowed. When these restrictions were off, the Reich made up for lost time and took advantage of rich international experience in interior planning and equipment.

These hospitals are staffed mainly by male orderlies. These orderlies have had experience with the troops on maneuvers and so are well equipped for present service in the fighting zone.

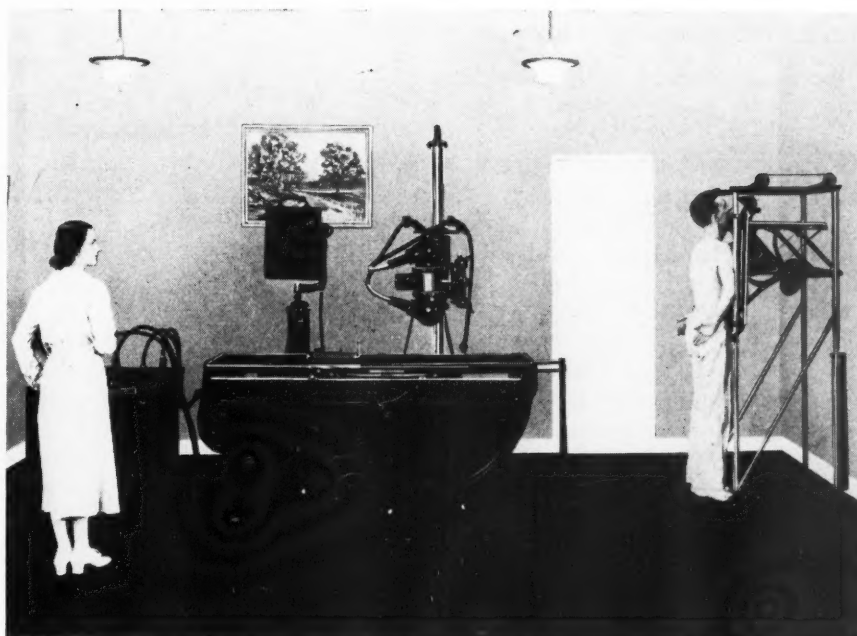
# Routine Chest X-Rays

Dr. MINAS  
JOANNIDES

IN ALL general hospitals today a urinalysis and a complete cytologic study of the blood are made for every new patient. These two procedures have aided materially in the discovery of renal or blood infections or the presence of an infectious process in the body. It is true that a large number of the blood and urine specimens, examined routinely, show no deviation from the normal; but it is worth the effort when a life is saved, when complications are diminished or when a more appropriate form of therapy is instituted as a result of data obtained from a certain number of patients who show infection in the urine or blood.

So it is also with the conditions in the chest. The use of the stethoscope and the percussion note is quite important but lacks the accuracy of detail that can be seen in a silhouette of the intrathoracic organs. Pulmonary and cardiac sounds do give gross changes and for the trained normal ear such changes are a treasure of information for the diagnosis of disease. The average physician, however, does not listen to the chest carefully enough or long enough, and consequently does not hear the finer changes in the sounds coming from a diseased lung. Furthermore, in our complex social life the noises about us are so numerous and variable that our sense of hearing has become quite dulled, thus cutting us off from the appreciation of the finer variations in sounds. Consequently, we have become less dependent on our sense of hearing and more dependent on our sense of sight.

Visual impressions, somehow, are more lasting. Realizing this fact, most of the better institutions of learning emphasize visual instruction and particularly visual instruction that is permanent. This is true of x-ray films of the chest. Not only do we see finer changes in the outline of the intrathoracic organs but we also have a permanent record of



Several large industrial plants make routine x-ray studies of chest organs.

these changes so that comparisons can be made from time to time and variations noted.

The use of the x-ray has been so popularized that x-ray machines have been installed not only in practically all hospitals but even in the offices of physicians who do not specialize in roentgenology. This is an evidence of the ever increasing realization by physicians of the value of x-ray studies of their patients. X-ray manufacturers, in response to popular demand, have placed on the market convenient portable units that are quite reasonable in price and can be used for fluoroscopic as well as radiographic study in the office or the home.

From a medico-legal aspect detailed information regarding chest findings is becoming more and more necessary inasmuch as the laws governing industrial compensation are becoming increasingly strict. Obviously, before long, most of the larger industrial plants will make routine x-ray studies of the chest organs to eliminate various conditions, such as pulmonary tuberculosis, pneumoconiosis, mediastinal disease, cardiac enlargements and aortic

aneurysms. All of these lesions can be found by the usual examination procedures but it takes so much less time to discover them by means of x-rays that a larger number of patients can be examined in the shortest possible time. Furthermore, x-ray evidence of disease becomes an incontestable legal record that can be filed away and used years hence if the necessity arises. In the employment offices of the larger industrial plants where the applicants seeking jobs try to hide important lesions of the chest, routine x-ray studies of the chest will not only eliminate the possibility of overlooking these lesions but will also give the examiner an opportunity to determine the physical fitness of an applicant for the position he seeks. The advantage to the applicant in submitting to such an examination is evident. He will be told of his disease and will consequently seek medical care.

We believe that it is only a matter of a short time before the life insurance companies will insist on an x-ray study of the chest of all applicants for life insurance. Though their statistical studies are quite ac-

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**Third in a series of articles on Hospitals and the Tuberculosis Problem is this plea of a practicing physician for hospital cooperation in early diagnosis. X-ray evidence is often demonstrated when there are no physical symptoms**

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curate, the figures obtained are based primarily on lesions that have caused disability or death. With the ordinary chest examination the medical examiners often may miss the true state of affairs in important organs, such as the heart and lung, with the result that a certain number of applicants will receive compensation earlier than the period of expectancy based on actuarial studies. Such errors may cost the insurance companies many thousands of dollars with the result that either the rates are increased or the dividends are decreased.

From a public health aspect routine x-ray studies of the chest organs will aid in the diagnosis of latent syphilitic lesions of the heart or such stages of pulmonary tuberculosis as are often elusive enough to escape even the ear of the expert diagnostician. In our work we have had occasion to review a large number of chest films taken of patients who present themselves as contacts to active tuberculous patients or who have a persistent cough. We have occasion to see as many as 1800 chest films every month and have repeatedly found x-ray evidence of pulmonary tuberculosis when there were no obvious physical signs or symptoms. We have encountered accessory ribs (cervical ribs) in patients who never presented any evidence of pressure from them, and it was a source of pleasant surprise to them to know they had more ribs than the average. Situs inversus, or pseudodextrocardia, is a source of increasing interest in the routine study of the chest. Such knowledge is of extreme value to the patient when certain conditions, such as acute appendicitis, develop. Other lesions, such as aortic aneurysm,

quiescent or early tuberculous lesions of the lungs, bronchiectasis, broncholithiasis, silent tuberculous cavities, pleural effusion, mediastinal or pulmonary emphysema, pneumoconiosis, cardiac enlargement, pulmonary abscess, pulmonary or mediastinal neoplasms and deformities of the thoracic cage, are but a few of the many that may be picked out at random with the routine x-ray study of the chest organs.

The facts presented are a few of the arguments in favor of routine x-ray study of all patients admitted to general hospitals. It is obvious that such a routine will be of benefit to the patient because he will be given an opportunity to have a record of his chest organs for comparison at a later date. If disease is present, the patient has a greater opportunity to improve because it will be treated at an early stage

before the organs are seriously damaged. If he has a transmissible infection of the lung, he can take proper steps to prevent infection of his friends and relatives. This routine will also aid the physician in obtaining more information about his patient so that he can establish his treatments on a more solid foundation. He will also have the opportunity of finding conditions not complained of clinically and thus be of greater service to his patient.

The roentgenologist will profit both materially and scientifically, particularly if he arranges with the industrial plants and insurance companies in his vicinity to do their routine chest x-rays in the x-ray laboratory of the hospital. Finally, the hospital will be aided materially in its objective of offering greater service to the community in general and to the individual patient.

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## War Measures in Great Britain

ALL hospitals of Great Britain have been placed at the disposal of the government for the period of the war. In London unified control is being extended to cover the large voluntary hospitals, at their own request, it is understood. Twelve teaching hospitals in the metropolitan area have asked the Ministry of Health to appoint a director who will assume complete control of war emergency service.

That increased efficiency will result is proved by the experience of the London County Council hospitals, more than 70 of which have been operating under a unified control.

Partial evacuation of the hospitals of London and other populous centers has been accomplished with machine-like efficiency, according to press reports and to personal correspondence. Such patients as were able to be transported by rail, bus or private motor car have been taken for further treatment and convalescence to hospitals, nursing homes and private estates in the country or in smaller towns. This frees much ward space and many private rooms for the care of the casualties of war.

Everywhere persons of title and other owners of country estates are

setting up accommodations for the care of wounded and for convalescent soldiers. A number of these estate owners at present are taking care of sick patients from the civil population, blind and handicapped school children and other persons requiring special care.

The Royal College of Nursing is taking charge of the registration of graduate nurses, earmarking them for service and distributing them to the various sectors in which the hospitals of the London area have been divided under the emergency hospital program.

Air raid precautions have been carried out in all hospitals; sand bags may be seen piled up above the ground floor windows and on the roofs. The new Westminster Hospital has a 6 inch layer of concrete over the whole roof area and the two floors below. By special tubular steel struts emergency support can be given the lower floors and basement should the building threaten to collapse if struck by a high explosive bomb.

Registration of volunteers at the blood donors' bureau continues apace. A total of 1,180,000 suitable prospective donors between the ages of 18 and 65 are being sought.

# Learning in the Operating Room

LUCILLE PETRY, R.N.

**L**EARNING in the operating room is a particularly appealing topic for discussion since it exemplifies certain principles of education more clearly than can learning in any other department of nursing.

The warp of the fabric of nursing education is the formulation of objectives or a statement of what it is we wish the nurse to be able to do and to be. The woof of the fabric of nursing education is discovery of what kind of person the student of nursing is, *i.e.* what she brings to it by way of personality, aptitude, knowledge, interest and self-formulated goals. Nursing educators take this warp and woof and weave a fabric.

## Objectives to Be Reached

Let us examine some of the objectives of the operating room experience and teaching. One of the most important objectives is that the student should see scientific principles in operation. These principles are neatly exemplified in the sterilization procedures and in all of the activities directed toward creating and maintaining an aseptic field. Principles of anatomy are also demonstrated when the student observes the handling of structures and sees their functions repaired.

The second objective is that the student, in her effort to understand the patient's care as a whole entity, should see the contribution of surgery to that care.

Another objective of the operating room experience provides that the student learn the care and intensive use of many types of equipment. Still another is that the operating room should be seen as an example of the advantages of mutual understanding of shared purposes on the part of these departments. Finally, the student should recognize the skills practiced in the operating room as examples of artistic precision.

Miss Petry is a member of the faculty of the University of Minnesota School of Nursing, Minneapolis.



"Preventive Medicine and Surgery," mural in the board room of Harlem Hospital, New York.

What are the learning activities by which a student will achieve the first objective, *i.e.* understanding what she performs in the light of scientific principles and learning to perform as skillfully as possible? Obviously she must understand the scientific principles that are exemplified in practice. It is the task of the operating room supervisor to discover the degree of mastery the student already possesses. Techniques for discovering what principles she already knows include the comprehensive pretest; conferences with the student during which she reveals how much she knows, and observation of the student, which shows whether or not she understands principles and sees how they apply.

As a first step in the learning activities we need to show the student

what she already knows, what there is to learn. Furthermore, she must be taught to recognize her practice and study in the operating room as a means of achieving these goals. It would be extremely profitable for operating room supervisors to spend a great deal of time in analyzing minutely the first objective, namely, that of seeing practice in the operating room as an application of scientific principles and becoming skillful in the operation of these principles. One reason for suggesting the comprehensive examination as a technic to help achieve this objective is that the making of the examination itself forces the supervisor to this minute analysis of the objective.

## Practical Application of Theory

Having decided the skills in which the student is to become adept and having graded these in order of their degree of difficulty, the supervisor plans demonstrations and discussions and supervised practice of each of them, constantly making her demonstrations show that operating room technic is the constant application of principles in practice. It is essential to determine in advance how far the student is to go toward the final stage of becoming a scrub nurse before this plan for demonstrations can be made. There is one exception to this general rule, an exception that should be made for the student who has some special reason or interest that is accompanied by aptitude for going farther than the average student can go toward becoming a scrub nurse. Each student should have experience in being gowned and gloved and should participate in some small way near the site of operation in order that she may observe the surgery and may appreciate the task of the nurse who assists at this time. She should develop considerable skill as a circulating nurse and should at all times be fully aware of the purpose of any steps she might be making.

Perhaps at this point we should



reword the objective under consideration. We are hoping that the operating room experience will enable the student to have understanding and appreciation of a great many scientific principles and that she will see what goes on in the operating room as the operation of these principles, but we do not expect her to have a high degree of skill in the operation of all of them. Just where the line is drawn at which she should stop is difficult to determine, but I believe that it is somewhere short of becoming a scrub nurse and, at the same time, it does include small amounts of participation and observation near the operative field.

At the close of experience in the operating room, the students should again be tested in order to determine whether they have achieved the objectives that were set for them. The next objective of operating room experience is that the student under-

stand the care of the patient as a whole and the contribution of surgery to that care. In this objective as well as in the first one we see need for consideration by the supervisor of the problem of listing the types of cases the student should see as a whole. Wise selection of a few cases that are thoroughly analyzed and show variety of social and psychological as well as surgical diagnoses will serve better than a large number of run of the mill cases.

The third objective is that the student should learn the care and use of many types of equipment. In ward practice she usually sees one or two types of syringes, one or two types of needles and a few common instruments. In the operating room she handles many kinds of syringes, needles and instruments and although we do not expect her to remember even the names of all of them she does achieve an apprecia-

tion of the precision with which types of instruments are chosen for particular functions. She gets a feel for the evolution of variations in instruments and the perfection of special types for special purposes. She should develop pride in the proper care of these instruments.

In order to develop facility in handling materials and instruments of all kinds she must have practice in handling them. But here again our objective does not call for the development of a high degree of skill, and the operating room supervisor will need to be careful lest too much meaningless repetition be included in the experience. It is not necessary for the student to wash rubber gloves several hours a day for several days in order to learn the method of caring for gloves.

The operating room supervisor who has charge of a dressing and supply room should assure herself

that students appreciate the complexity of such a service and the necessity for its efficient management; that they understand fully its relationship to the operating room and to the rest of the hospital, and that they understand the principles underlying the preparation and use of the commonest types of supplies. The practice in handling all these materials, however, should come preferably when the materials are put to use in the operating room and the wards rather than in their preparation. Here again we see supervision of a student circulating nurse as an important teaching procedure.

A fourth objective is concerned with having the student see the management of the operating room as a model of cooperation between departments, the wards, the supply rooms, the x-ray department, the pathology department and the purchasing department. The efficient way in which operations are scheduled and in which routine schedules are adhered to is an excellent example of fine management. The student will have little or no part in this management but should be made aware of the smooth way in which the elements of it fit together; she should be aware of the absence of personal friction in a situation fraught with possibilities for clashes. Since operating room practice is early in the student's course this is perhaps her first opportunity to see interdepartmental cooperation in achieving shared purposes and from her experience she should learn regard for the unique purposes of other divisions.

A fifth objective is that the student see the skills practiced in the operating room as examples of artistic precision. This precision will appeal to her sense of the esthetic.

This matter of student reaction to operating room experience brings up a point that was mentioned earlier, namely, the assets which the student brings to the service in the way of personality. What kind of person is she? Does she need reassurance? What is the basis of any fear she might have? I hope the days are gone when it was thought that only the bravest (or perhaps only the most hard boiled) could live through this service without tears.

The most wholesome agents for bringing out the attitude we desire in this department are naturalness and the maintenance of the spirit that this is a place where one learns, and learns definite things that are graded as to difficulty and that never is the learner expected to assume any responsibility for which she is not fully prepared. Each student is a different personality and reacts in a different way to each situation.

It is the supervisor's job to discover what the personality assets of the student are and to help her with her problems. Under good supervision I have seen students show development of remarkable self-assurance and equanimity in an operating room assignment. Luckily, most operating room supervisors are good mental hygienists. They have had much experience in maintaining smooth relationships in a situation full of tensions and emergencies. The student as well as the surgeon and the patient will receive the benefit of her superior understanding and handling of people.

The learning activities that bring about the achievement of the desired objectives include participation in discussion of principles; thinking through questions and problems with a view to discovering what one has yet to learn; intelligent observation of demonstrated technics; collecting information about patients to be operated upon by observing and talking with or caring for them in advance and by reading their history, especially social history; preparing patients for operation; receiving patients in the operating room; assisting with the administration of the anesthetic; setting up the room for operation; preparing sterile trays; sterilizing instruments; preparing the sterile field; running the autoclave; serving as circulating nurse; assisting others to glove and gown; scrubbing, gloving and gowning oneself; observing operations; observing postoperative and follow-up care of patients; looking up principles in reliable texts and references; assisting in bacteriological studies of sterile technics; attending doctors' clinics; preparing and giving demonstrations to other students; looking up costs in catalogs; studying anatomy, and studying eco-

nomics of insurance plans. It will be noticed that these are stated in terms of activity engaged in by students.

Operating room experience should be placed early in the student's course, perhaps between the sixth and twelfth month. For the achievement of these objectives (ruling out large amounts of wasteful repetition) a period of from six to eight weeks of practice should suffice in most instances. Technics of measuring the student's progress may change our present ideas of measuring her achievement by counting either the days she spends in the department or the operations for which she scrubs or circulates. For best achievement we believe that learning principles and learning through practice should be concurrent; therefore, all teaching should be done while the student is in the department.

Let us list criteria by which we may judge the teaching program. A good teaching program arises from the situation itself, has reality and solves immediate problems; it shows the relationship between principles and practice; it deals with all facets of nursing problems, *i.e.* scientific, technical, psychological, sociological, esthetic, economic, cultural and preventive; it fits the students' needs, and, finally, it results in improved care for patients.

### Reclaiming Alcohol

When alcohol is used in open basins for hand and instrument sterilization, it becomes unfit for use because of clouding from contamination and because of hydration resulting from evaporation. An easy method of purifying the alcohol is to add calcium chloride as a dehydrating agent and then filter the solution. One treatment is sufficient for most purposes but repeated treatment may be used if a high degree of purification is desired. In this manner by several treatments with calcium chloride the alcohol can be brought up to about 99 per cent or 198 proof.

Calcium chloride may be used several times by redrying so that the method is inexpensive, especially so, if one uses calcium chloride that has been discarded from basal metabolism machines. — HENRY G. HADLEY, M.D.

# Handle Fractures With Care

G. OTIS WHITECOTTON, M.D.

THE highly mechanized age in which we live has brought forth many time and labor saving devices that have contributed immeasurably to our everyday comfort and pleasure. High speed transportation is not the least of these blessings, but, while the mechanical safety factor of motor vehicles is increased each year, we still must deal with the human element. Individuals make mistakes, mistakes mean accidents and accidents at high speeds mean fractures with the chances for comminuted or compound types increasing in direct proportion to the speed. The more severe varieties require hospital care and it therefore follows that an ever increasing percentage of the million or more fractures occurring in this country each year must be treated in our institutions.

Such a situation places an enormous responsibility upon the shoulders of hospital administrators and we must be fully prepared to fulfill our obligation at a moment's notice, day or night. This is particularly true of those hospitals situated near main highways or in congested urban areas, since it is in such locations that serious accidents are most likely to occur and the injured are brought to the nearest institution.

## Adequate Equipment Necessary

No hospital has any right to accept such patients for other than emergency procedures unless it is adequately equipped to carry out the necessary treatment in a manner that can reasonably be expected to bring about a good result. It is far better to admit our inadequacies than to run the risk of a suit for malpractice, but it is better still so to equip ourselves that we will have no occasion to turn away any injured person.

Prompt reduction is highly desirable in any fracture involving the long bones but never in the presence of extreme shock, head injuries or possible internal complications. Members of the resident staff whose

The author is superintendent of Stanford University Hospital, Calif.

duty it is to care for emergency admissions pending the arrival of the attending physician must be cognizant of this fact and be prepared to take heroic measures should the occasion arise. With this thought in mind every hospital should have one or more well-equipped emergency admitting rooms adjacent to the ambulance entrance to which such cases as have not been seen by a physician before admission may be taken for a complete examination.

Such a room should be equipped to carry out any procedure short of major surgery. If the condition of the patient will permit there is no reason why the entire treatment cannot be given right here, thus saving him the discomfort of an unnecessary trip to the x-ray department and then to surgery. Present day mobile x-ray units give results that are entirely satisfactory. Compound fracture wounds can be irrigated, debrided and sutured; an anesthetic can be administered, and the fracture reduced and immobilized as easily in the emergency room as in the surgical unit.

Should the condition of the patient be such as to require delay in carrying out final procedures all fractures of long bones should be immobilized with well-padded splints to limit muscle spasm and possible compounding of simple fractures. This is particularly important in alcoholic patients. Measures should be instituted for the relief of pain, although it should be remembered that morphine may mask the diagnostic signs of a head injury. Patients with compound fractures or wounds contaminated with street dirt should be immediately skin-tested for the administration of gas gangrene and tetanus antitoxin. A plentiful supply of the combined serum in both prophylactic and therapeutic dosages should be kept on hand.

The hospital will find it an asset to have the top of the treatment table in the emergency rooms rigid and removable so that it may be lifted with the patient on to a wheeled

stretcher and transported with him to his room. There, the table top can be taken off the carriage and so tilted that the patient may be gently slipped into bed without being lifted, a maneuver fracture patients dread.

Beds for the accommodation of fracture cases should be of the 7 foot variety and of sturdy construction. It is desirable that there be some method of placing a bedpan under the patient with a minimum of effort on his part. The bed should have a low foot to allow for projecting splints and the various forms of traction apparatus. Balkan frames may be of wood or pipe although the latter are to be preferred since they can be fastened rigidly to the head and foot of the bed and this form facilitates the attachment of lateral extensions at various points.

## Care of Convalescents

Despite new departures and innovations in the care of fractures which have brought about better clinical results we are still confronted with an extended period of callus formation during convalescence. In those conditions that necessitate the patient's remaining in bed the hospital is obliged to provide the best in nursing care. Many patients cannot be turned in bed and the possibility of hypostatic pneumonia and decubitus must be constantly borne in mind, with every effort being made to preclude such conditions.

Hospitals that accept cases for orthopedic surgical procedures must be fully aware of their responsibilities and be prepared to give their utmost in service. Such cases are notorious for their tendency to become infected and, in view of this fact, every safeguard must be provided. The pre-operative preparation must be carried out in a most meticulous manner. It seems unnecessary to point out that any operating room procedure demands the most careful aseptic technic but bone is a tissue that lacks the resistance to infection enjoyed by other parts of the human body and in this type of work the need for caution reaches its peak.

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# The Convention News

October 1939

## A.H.A. Officers

**President:** Fred G. Carter, M.D., St. Luke's Hospital, Cleveland.

**President-Elect:** Benjamin W. Black, M.D., Alameda County Hospitals, Oakland, Calif.

**Treasurer:** Asa S. Bacon, Presbyterian Hospital, Chicago.

**First Vice President:** Edgar Hayhow, Paterson General Hospital, Paterson, N. J.

**Second Vice President:** Msgr. John Mulroy, diocesan director of Catholic Hospitals, Denver.

**Third Vice President:** Mrs. Jewell Thrasher, Frasier Ellis Hospital, Dothan, Ala.

**Trustees for Three Year Terms:** Msgr. Maurice F. Griffin, Cleveland; Henry M. Pollock, M.D., Massachusetts Memorial Hospital, Boston, and George D. Sheats, Baptist Memorial Hospital, Memphis, Tenn.

## Canadian Hospitality Is of Superior Brand, Find Delegates to Convention

By Jane Barton

Delegates to the American Hospital Association convention discovered that Canadian hospitality is right up in the running with the more widely touted Southern hospitality. Toronto turned out in a big way to give its American visitors a good time. On Tuesday afternoon, the Royal Ontario Museum held open house and a tea for the convention-goers. To make it easy for the visitors to attend, generous citizens put their private cars at the disposal of the transportation committee and drove delegates both to and from the museum. The party of some fifty carloads started from the exposition grounds and was escorted to the museum by motorcycle police. This scooting through the center of town, through red lights, added zest to the occasion.

The entire visit of the King and Queen, which had been recorded in color film, was unrolled before the eyes of those who accepted the cordial  
(Continued on page 70)

## Peaceful Convention Held in Country Now at War; Black and Boston in 1940

While highland regiments paraded the streets and rookies drilled on the exhibition grounds, the forty-first annual convention of the American Hospital Association swung into action on all fronts, save the sectors that were to have been manned by the International Hospital Association and the American Occupational Therapy Association. The I. H. A. was interned in foreign ports and the occupational therapists withdrew into neutral waters.

Although the war was unofficially on every tongue, the planned programs were actually little affected by it. They went off exceedingly well, on the whole, and with less argument than usual, no doubt as a result of this preoccupation with war demands.

Registration was not record breaking. Unofficially, it was reported to be around 3000 but final figures were not available.

Last year's fiery arguments over the medical and health bills had no counterparts in this year's proceedings. There was considerable discussion on John Mannix's request that the membership structure of the A. H. A. be widened to permit institutional membership of approved hospital service corporations. No action was taken on the proposal.

One of the largest meetings was that of the section on hospital service plans, with 500 in the hall at the morning session and 400 attending the afternoon session. Other banner sessions from the standpoints of attendance or



President-Elect B. W. Black

Arden Hardgrove as chairman. Many of these men and women are full-time purchasing agents.

The attendance of several representatives of the Latin-American countries was a pleasant feature of the convention. There was enthusiasm over the prospect of a Pan-American Hospital Association.

Puerto Rico was taken into the A. H. A. on the same basis as Hawaii and will hereafter send a delegate to convention.

Canadian hospitality, all delegates agreed, is of a superior brand. Weary and worn as were the hosts with such problems as cancellation of I. H. A. plans, getting exhibits and delegates through the customs with a minimum of delay and difficulty and the perplexing demands of war on their own institutions, they were charming and indefatigable in arranging for the comfort and entertainment of their guests. The usual resolutions of appreciation were more than mere form and were heartfelt.

### Cedar Gavel Presented to A.H.A.

In commemoration of the three-hundredth anniversary of the Hôtel Dieu in Quebec, a cedar gavel made of wood from the original hospital was presented to the American Hospital Association on behalf of the Canadian Hospital Council by Dr. George F. Stephens, president of the council. Hôtel Dieu was visited by a number of convention delegates.

### Boston and Atlantic City Next

Boston was selected as the convention city for 1940 and Atlantic City, for 1941 by action of the trustees of the American Hospital Association in Toronto.

enthusiasm were the administrative section on Thursday morning, the public relations round table on Thursday afternoon and the trustees' section on Tuesday evening.

An impromptu gathering was that of purchasing agents, 53 of whom met at breakfast on Thursday morning with

# War Threatens Personnel Shortage to Canadian and Possibly U. S. Hospitals

By Alden B. Mills

War and the many hospital problems that arise from war occupied the center of the stage for the delegates to the meeting of the Canadian Hospital Council.

Already there have been instances of skilled hospital personnel volunteering for military service and leaving positions that cannot be filled. In order to avoid the waste of personnel resources that is involved when an ophthalmologist, for example, is assigned to abdominal surgery and also to avoid depleting certain areas of medical service completely, the Canadian Medical Association is offering to categorize the medical profession and to set up an advisory board in each province to cooperate with military authorities in selecting doctors and assigning them to duty in the most effective manner. The Canadian Nurses' Association is now engaged in classifying its members for war service.

The problem of what status to accord men going into military service is causing careful thought on the part of the Canadian hospitals. Some hospitals have agreed to make up the difference in pay involved in army service and to reinstate physicians or personnel at the end of the war, if they are then able to carry on their functions.

Persons who are appointed to hospital medical and administrative staffs to replace those going into military service are being told by many Canadian hospitals that their employment is temporary and that if they leave for war service they will not be entitled to reinstatement on the same basis as those employed as of September 1.

Canadian hospitals anticipate a shortage of nurses if the war continues for a considerable period. For the present they are not increasing nursing classes, however, feeling that it is better to absorb the 3500 nurses in the dominion who are now unemployed before any additions are made to the nursing supply. Standards of nursing education will not be lowered to meet the emergency but, rather, classes will be increased.

A shortage of laboratory and x-ray technicians, chemists, physiologists, physical and occupational therapists and similar groups is anticipated soon. Several of the Canadian leaders believe that this shortage will affect the supply of such specialists in the United States if the war continues long.

Rising wage scales for hospital employees, resulting partly from the war and partly from the general trends of

the period, have presented the Canadian hospitals with serious problems. Some hospitals have been forced by legislative act to meet high wage levels for their less skilled help. This necessitates the readjustment of wage levels all along the line, adding greatly to hospital costs. Rising food costs, decreased revenues and a changed intern schedule are anticipated effects of war.

The possible effect of war upon the movement for compulsory health insurance was considered by the council. The two phases of the problem are logically inseparable and, unless a special effort is made, the individual and medical phase of the problem will be studied to the neglect of the hospital service phase.

Dr. George F. Stephens was re-elected president.

## Nurse Anesthetists Change Name of Their Organization

The National Association of Nurse Anesthetists voted to change the name of the organization to the American Association of Nurse Anesthetists. This was the most interesting change made by the adoption of a new constitution and by-laws. An executive committee was created that will bring the activities of the organization more closely together.

Excellent attendance featured the meetings. Miriam G. Shupp, Strong Memorial Hospital, Rochester, N. Y., was chosen president; Sister Barromea, Peoria, Ill., was elected as first vice president; Rose Littel, Minneapolis General Hospital, Minneapolis, was selected as second vice president; Mrs. Gertrude L. Fife of the University Hospitals, Cleveland, was made treasurer, and Theresa McTurk of Philadelphia became a trustee.

## A. H. A. Transactions Will Not Be Reduced in Size

Advocates of reducing the amount of material published in the Transactions of the American Hospital Association were voted down at the house of delegates' session on Tuesday.

It was held that reduction in the amount of this material would detract from the value of the Transactions as a reference volume. No resolution was passed on the subject but the publication committee was given the point of view of the users of the volume in regard to eliminating data.

## Anesthetic Gas Explosions Subject of Special Study

An appropriation of \$1000 by the A.H.A. to help in financing a study of anesthetic gas explosions was reported by the council on hospital planning and plant operation. It is hoped that other funds may be obtained to carry on this study, which will probably cost from \$10,000 to \$15,000 in all.

The study will be designed to discover methods of preventing explosions of available anesthetic gases and to develop new anesthetic gases with less explosive hazards. Dr. Lucius R. Wilson, chairman of the committee, was warmly commended by members of the house of delegates for cooperating in this study and various suggestions were made for obtaining the funds needed to carry on the research.

Considerable criticism was voiced over delay in the publication of the manual on the standardization of hospital supplies and equipment, initiated by John N. Hatfield and carried on by a committee under L. M. Arrowsmith. There seemed to be general agreement that the manual should be published as soon as funds are available.

## Collections, Inclusive Rates Discussed at Business Session

A hospital collection officer should have good collection experience and, in addition, should be courteous, energetic and possessed of a broad view of the hospital's place in society, declared George P. Bugbee, superintendent of the Cleveland City Hospital, speaking before the section on business management.

If a hospital's collection officer is doing a good job he can collect anything a collection agency can, Mr. Bugbee affirmed. The speaker advocated that definite standards for admission and for payment should be established; that the merits of each case be surveyed in the light of these standards, and that written records be kept of all agreements. A financial history of each patient should be kept that corresponds to the clinical history in its accuracy, he said.

A debate on inclusive rates between James V. Class, University Hospitals of Cleveland, and Ray M. Amberg, University of Minnesota General Hospital, was rather one-sided when Mr. Amberg admitted that, in spite of the fact that he argued against them, he personally does not condemn inclusive rates. Nevertheless, he brought out some of the problems and difficulties that are entailed by inclusive rates. The most important of these seems to be the too rapid increase in the use of services.

## Advisory Committee of Educators Will Appraise and Interpret Work of A.C.H.A.

An advisory committee of college presidents and other educators is to be set up by the American College of Hospital Administrators to help appraise the present educational program of the college and to interpret it to the educational field. This was decided by the officers of the college meeting in Toronto.

The code of ethics now in course of preparation by the college will cover hospital practices as well as the practices of hospital administrators, because, according to Dr. G. Harvey Agnew, chairman of the drafting committee, it is impossible to consider merely the administrator's personal conduct. Doctor Agnew's committee has already received many suggestions of items that should be covered in such a code.

It was reported by Gerhard Hartman, executive secretary of the college, that there are demands for institute work of sufficient quality to merit and receive university credit and for an advanced type of educational program for persons of fellowship caliber. Consideration is being given both these demands.

A suggestion formally presented by Maurice Dubin of Sydenham Hospital, New York, that the college request the American College of Surgeons and the American Medical Association to require some evidences of competent administration before granting approval and registration was approved in principle. The matter had already been referred to a committee for consideration.

The coming year in the college will be one of conservation and self-criticism rather than one of greater expansion of activities, promised James A. Hamilton, the incoming president in his presidential address. Mr. Hamilton examined the college and the hospital field as a whole in an attempt to determine whether hospital administration yet merits designation as a profession. While acknowledging many weaknesses still remaining in the character and quality of administration, he feels that on four of the five criteria of a profession hospital administration is able to qualify.

The fifth criterion, namely, the possession of public respect and recognition, is as yet a hope. "Recognition will be accorded to us," he promised. "in proportion to the height of our standards and the number of distinguished members among us."

Hospital institutes, the A.C.H.A. president declared, should be "mind

### New A.C.H.A. Officers

*President:* James A. Hamilton, New Haven Hospital, New Haven, Conn.

*President-Elect:* Arthur C. Bachmeyer, M.D., University of Chicago Clinics, Chicago.

*First Vice President:* Fred M. Walker, Duval County Hospital, Jacksonville, Fla.

*Second Vice President:* Alice G. Henninger, Huntington Memorial Hospital, Pasadena, Calif.

stretchers" as well as "fact dispensers."

A warning against too much concentration upon purely technical and utilitarian training in hospital administration was voiced by Prof. Malcolm Wallace of the University of Toronto. "It is well to work hard and to achieve ends but it is also well to dream and speculate and to decide what ends are worth achieving. The cultivation of the imaginative life aids in the happiness of living and also increases the capacity for able work. I plead for the ideal of a professional man who is something other than a great technician," the distinguished educator said.

The convocation, the largest in the history of the college, was held in the early afternoon. It was an impressive ceremony. Dr. Benjamin W. Black was convocation speaker.

### Latin-America Well Represented

Dr. Aristides A. Moll, head of the Sanitary Bureau of the Pan-American Union, Washington, D. C., spoke on "Hospital Development in Latin-America," at the Wednesday evening session on government and hospitals. Doctor Moll pointed out that the presence in Toronto of several representatives of Latin-American countries indicates the increasing interest of Latin-America in better hospitalization. Doctor Moll stated that the ratio of beds per population is improving in the metropolitan areas of the Latin-Americas.

### Venetian Blinds Step Out

Venetian blinds, having achieved the height of success for indoor use, now step outdoors. Perhaps it might be fairer to describe them as all metal venetian awnings adjustable from the inside. They are galvanized metal, bonderized to hold paint. Whether they will duplicate the popularity of their less rugged cousin remains to be seen. They were shown for the first time in Toronto.

## Pan-American Association Is Urged

The formation of a Pan-American Hospital Association to foster greater cooperation among hospitals in the western hemisphere was advocated by many leading speakers at a breakfast meeting of the International Hospital Association. There was widespread informal discussion, uniformly favorable. Several representatives of Latin-American countries who were present received the suggestion warmly and urged its immediate realization.

Dr. G. Harvey Agnew, who supported the idea originally presented by Dr. S. S. Goldwater several days previously, also suggested that large delegations of hospital people from the New World might well attend the conventions of the British Hospitals Association at periodic intervals. Similar delegations from Great Britain might likewise attend conventions of the American Hospital Association. Thus British delegations might come here in 1940, 1944 and 1948, while delegates from this side would go to Britain in 1942, 1946 and 1950.

Among the Latin-American repre-

sentatives who supported the proposal for a Pan-American Hospital Association were Felix Lamela, School of Tropical Medicine, San Juan, Puerto Rico; Dr. G. C. Fricke, Hospital de Viña del Mar, Valparaiso, Chile; Dr. José W. Tobias, director general of public health, Buenos Aires, Argentina, who is also associate professor of clinical medicine of the Medical Faculty of Buenos Aires, and Dr. Angel M. Abadie Acuña, representing the National Commission of Sanatoriums and Asylums of Argentina.

After spending eighteen months in touring the world to study hospitals, Doctor Fricke declared that he believes the only possibility of effective cooperation is in the western hemisphere.

Dr. Malcolm T. MacEachern, president of the International Hospital Association, asserted that he did not wish to see that organization discontinued on account of the war and stated that he hoped it might be revived when the war is over. It must, of course, remain static during the period of hostilities.

## National Hospital Day Winners—1939

### Cities of Less Than 15,000 Population

*A.H.A. Award:* Hinsdale Sanitarium and Hospital, Hinsdale, Ill.

*Publicity Award:* Paradise Valley Sanitarium and Hospital, National City, Calif. (for third consecutive year).

*Honorable Mention:* St. Luke's Hospital, Marquette, Mich.; Valley Baptist Hospital, Harlingen, Tex., and Mauston Hospital, Mauston, Wis.

### Cities of More Than 15,000 Population

*A.H.A. Award:* Cleveland City Hospital, Cleveland.

*Publicity Award:* New England Sanitarium and Hospital, Stoneham, Mass.

*Honorable Mention:* Port Huron Hospital, Port Huron, Mich.; Ball Memorial Hospital, Muncie, Ind.; Peralta Hospital, Oakland, Calif.; Lima Memorial Hospital, Lima, Ohio; St. Luke's Hospital, Milwaukee, and Mercy Hospital, Soniat Memorial, New Orleans.

### Community-Wide Observance

*A.H.A. Award:* Dallas, Tex.

*Honorable Mention:* Flint, Mich.; St. Louis, and Honolulu, T. H.

Special honorable mention was given for the observances at the New York and San Francisco fairs.

## Both State and Regional Associations May Share Hospital Day Awards

The formation of a new class of competitors for National Hospital Day awards was recommended by the committee in charge, so that recognition can be given to outstanding work rendered by state and regional hospital associations.

The committee was especially impressed by the tremendous amount of excellent work done, particularly in the middle-sized and smaller towns.

Concern was expressed by the committee, however, over growing evidences in some places of commercialism creeping into the observance of National Hospital Day and institutions were warned that this tendency should be checked. The committee also reaffirmed its stand that National Hospital Day should not be a day for the solicitation of funds from the public.

## A.H.A. Should Sponsor Program of Public Education—Davis

An effective program of public education should be carried on by the American Hospital Association on a cumulative and continuous basis, according to the report of the council on public education presented by Michael M. Davis and adopted by the house of delegates.

"Such a program cannot take the place of the work of individual hospitals in local public relations," the report stated. "However, a national agency can both assist individual hospitals in public education and publicity and also perform certain services in creating public understanding and good will toward hospitals which no local or regional efforts can accomplish.

"The council recognized that the effective conduct of such a program would require adding to the present staff of the association a qualified person who could give a large part of his time to it. It repeated the recommendation of the coordinating committee that such a person be employed to act as executive officer of the seven councils, to carry on public education work and to direct and coordinate National Hospital Day activities. The board of trustees was urged to consider and to

act upon this recommendation at the earliest date consistent with the association's interests and resources."

## The National Health Program Is Not a Dead Issue—Munger

"Let us not delude ourselves into thinking that the issue of a National Health Program is legislatively dead," declared Dr. Claude W. Munger speaking for the council on government relations. The issue is very much alive, he declared.

"This association has been invited to suggest concrete amendments to the subcommittee. This council will cooperate with the president-elect and the joint committee in preparing these suggestions even though, in our opinion, the Wagner Bill will need, practically, to be rewritten if it is to provide a rational and workable program."

Doctor Munger declared that the present largely negative program of the association on national legislation should be replaced by a positive and constructive one.

The need for an employed person to work under the direction of the council in keeping in touch with legislative developments and helping to formulate a positive program was stressed.

## A.H.A. Award of Merit Is Given Doctor MacEachern

Dr. Malcolm T. MacEachern, president of the International Hospital Association and associate director of the American College of Surgeons, was signally honored by being presented with the American Hospital Association award of merit signalized by a gold medal. Some years ago a similar award was given by the association but the custom was discontinued because of the difficulty of deciding on what basis it was to be granted.

The presentation by the Rt. Rev. Msgr. Maurice F. Griffin on behalf of the trustees mentioned, among other things, Doctor MacEachern's outstanding service as president of the American Hospital Association, as director of the Institute for Hospital Administrators at the University of Chicago, as leader in the movement for hospital standardization, as author, counselor, guide and friend.

## Survival of Voluntary Hospitals Depends on Service, States Agnew

Voluntary hospitals have been largely eliminated in Germany, Russia, France and many other countries, declared Dr. G. Harvey Agnew in his presidential address. He pointed out that in the United States and Canada there is a tendency to get away from direct payments by patients to hospitals and he asked whether this would mean that voluntary hospitals would gradually be replaced in these countries.

"The answer undoubtedly will lie in the character of service given to the public. If the voluntary hospitals are more efficient, more economical and more filled with the milk of human kindness, they will continue to thrive," the president declared.

The problem is coming from the financial side, Doctor Agnew believes. He anticipates conditions arising which will require much larger sums than have recently been available. Unless standards are to be reduced, a solution that he is unwilling to accept, some support must come from society.

Doctor Agnew urged the general adoption of a carefully planned basis of cooperation between voluntary agencies and the state. This would open new vistas of service.

"State assistance is preferable to state control or state competition," Doctor Agnew pointed out. "Let us be sensible and work with our governmental bodies on this problem rather than bickering back and forth and ultimately losing the voluntary hospitals."



National Hospital Day Scenes  
at  
**Hinsdale Sanitarium & Hospital**  
Hinsdale, Ill.  
1939 Award Winner in Small City Class



## Service Plans Challenged to Provide Low Cost Hospital and Medical Care

Hospitals and the medical profession were directly challenged to provide low cost medical and hospital care on a voluntary insurance basis by a business leader, a physician and a hospital administrator who spoke at the session on hospital service plans.

"If we may assume for the moment that the people who can pay their hospital bills without real hardship are in the topmost third of income brackets and that the lowest third is composed of the chronically indigent, it is the middle third of our population to which we should direct our hospital insurance plans," said Dr. Basil C. MacLean, chairman of the commission on hospital service.

"If voluntary plans do not meet that need, I am afraid they will crumble under a compulsory governmental system. When cold analysis is substituted for emotion, it surely is evident that a health program of some kind is inevitable in the United States. It is no longer a partisan issue even though its flavor is subject to political debate. We must be more realistic and less hysterical if we are to avert a broad program of compulsory health and hospital insurance.

"The average citizen," Doctor MacLean continued, "is likely to suspect our sincerity if we slobber about our charity and scream for the status quo. He questions our consistency when we denounce governmental aid while we jostle to get to an alphabetical feed trough. If political control is pernicious, should we not show that it is un-

necessary? The alternative is an extension of the voluntary type of insurance deep into the lower income groups. The ward plan seems now to be the only way thus to broaden the base, and the ward plan will not do it unless it provides medical care inclusively or collaterally on a budgetable basis."

This point of view was effectively supported by Dr. Channing C. Frothingham, past president of the Massachusetts Medical Society. He urged voluntary health insurance under non-profit auspices to provide as nearly complete medical service as is administratively and financially feasible. He especially urged that it should lay emphasis on prevention and utilize specialists effectively. "Free choice of practitioner, as a catch phrase, should be replaced by wise choice of practitioner," Doctor Frothingham declared.

A direct challenge to hospitals to develop ward service plans that will actually provide the kind of service that low salaried employees need was presented by Thomas S. Gates Jr., president of the Associated Hospital Service of Philadelphia. He asked hospitals to think less in terms of hospital insurance and more in terms of distributing hospital service to the community as needed. Business men, he declared, are going to buy hospital protection where they can best obtain it, whether that is from a nonprofit hospital insurance organization, a commercial insurance company or from the government.

### Hospitals Advised to Seek Aid From Local, Not State or Federal Sources

Time we looked ourselves frankly in the face, William J. Orchard, trustee, Orange Memorial Hospital, Orange, N. J., believes.

"Our voluntary hospitals cannot run unless they are operated as a business, but there are all kinds of business," according to Mr. Orchard. "We must think from the standpoint of volume and the cost of rendering service. The increasing difficulty in getting funds with which to carry on directs attention to government assistance. Get necessary support from the smaller government units or municipalities rather than from state or federal sources. Also, never permit government assistance to dominate; rather, let it guide us. No government program is going to take out of the voluntary hospital

system the spirit of doing for others that has prompted men and women to devote a portion or all of their lives to its cause."

One of the differences between the organization of English and of American voluntary hospitals lies in the public concept of their service. In America these institutions have too frequently been interpreted as profit making, while in England they have never been regarded as mercenary. This point was emphasized by Graham L. Davis of the Duke Endowment, Charlotte, N. C., in discussing a paper by Capt. J. E. Stone, consultant of hospital finance to King Edward's Hospital Fund for London.

We should provide for our employees under the old age security act and pay the costs, according to Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N. Y. Doctor MacLean's paper on voluntary hospitals and the social security act was

discussed by James M. Hamilton, superintendent, New Haven Hospital, New Haven, Conn.

Also included in this program was a discussion of diagnostic clinics by Frank E. Wing, director of the Boston Dispensary and the Joseph H. Pratt Diagnostic Hospital, and by Howard E. Bishop, administrator, Guthrie Clinic and Robert Packer Hospital, Sayre, Pa.

### Puerto Rico Forms Hospital Council, Lamela Is President

The organization of the first hospital council in Puerto Rico was announced at the convention by Felix Lamela, director of the University Hospital of the School of Tropical Medicine, San Juan, Puerto Rico.

Mr. Lamela was elected president of the council. Other officers elected include Ricardo Fernandez, owner and director of the new Institute of Ophthalmology, San Juan, vice president; Robert Boyd, business manager, Presbyterian Hospital, San Juan, secretary, and Dr. Louis Gonzales, inspector of government hospitals, treasurer.

The council plans to send a delegate to the American Hospital Association convention each year. Mr. Lamela was chosen to represent the council at this convention.

### Canadian Hospitality Is Declared Superior Brand (Continued from page 65)

invitation of T. Eaton & Company to visit the Eaton store Wednesday evening to see the film and to stay for the reception afterward.

Catholic Sisters had a full program of visits to hospitals and sightseeing trips around town. On Tuesday afternoon they were picked up at the convention hall and taken for a tour in the city. A reception was held in the evening at St. Joseph's College and motion pictures were shown in the auditorium of the college.

On Wednesday afternoon there was a trip to the famous Martyrs' Shrine at Midland. The shrine is a national memorial to Jesuit martyrs of North America and its religious and historic associations have made it a center of interest to visitors from all over the world.

Another Canadian contribution to the entertainment of the association, and one that was particularly enjoyed, was the colorful and impressive ceremony of trooping the colors by the 48th Highland regiment of Canada that was a feature of the annual banquet held on Thursday evening.

## Soil of Many States Sprinkled on Foley Memorial Maple Tree

Soil from nearly every state and province of the United States and Canada was deposited at the base of a maple tree planted on the University of Toronto campus during the convention. The tree was dedicated to the memory of Matthew O. Foley, founder of National Hospital Day. The presentation was made by Dr. G. Harvey Agnew, president of the American Hospital Association, and was accepted by Canon Cody, president of the university.

The soil from Indiana was taken from the birthplace of Abraham Lincoln; that from Kentucky, from the birthplace of Mr. Foley, and that from Maryland came from Fort McHenry. The delegate responsible for bringing soil from Minnesota forgot to obtain it until after boarding the train. The railroad officials stopped the streamlined train long enough to obtain a sample of true Minnesota soil.

## Group Practice Urged by Depage

Strong support for the idea of group practice was voiced by Dr. Pierre Depage's committee on the organization of diagnostic and preventive institutions connected with hospitals. Doctor Depage is associated with the Clinique Antoine Depage of Brussels, Belgium. "The medical group," stated the committee, "includes internists and specialists, with a view to a close working collaboration. Its aim is to place at the disposal of doctors an organization through which they can find without loss of time all the elements necessary for establishing a difficult diagnosis and on terms that do not exceed the financial means of their clients."

## Ohio Hospitals Gain From New Motor Vehicle Law

More than \$2,000,000 has already been paid to the hospitals of Ohio for the care of indigent patients injured in automobile accidents under the motor vehicle law of that state, it was reported by Dr. M. F. Steele, chairman of the state relations committee, at a luncheon of the Ohio Hospital Association held during the convention week.

Doctor Steele strongly urged that hospitals do not try to seek exemption from every type of social welfare legislation proposed but attempt to cooperate with the state legislators and officials whenever possible. "This will give us a better standing with state officials and make it easier for us to obtain the legislation and official rulings we desire," he affirmed.

## Exhibitors Spread Their Wares Before Buying-Minded Delegates

Raymond P. Sloan

If somewhat fewer in number than in preceding years, the exhibits staged in the Convention Hall at the A.H.A. meeting appeared to excellent advantage in a setting distinctly modern. The large area provided by Toronto's beautiful show building on the lake front made possible broad aisles and spacious lounges with the result that, despite the large numbers attending, there was no crowding.

Business was good. Hardly an exhibitor that did not express satisfaction with the interest which, in many instances, developed during the week into substantial orders. There were names familiar to all, also some new entrants in this mart of hospital equipment. At every turn was something of interest, presented in striking manner.

Laundry equipment occupied a front position, one manufacturer presenting what was practically a complete laundry setup. Washing machines of all sizes were on display and to add a note of realism uniforms were discovered stretched on the mangles. Dishwashing in soap sudsy water was a frequent sight, proving the efficiency of methods of assuring cleanliness for hospital dishes. The method of sending dishes straight from the tray into the washer was demonstrated effectively to the satisfaction of the crowds.

Color was everywhere—in the displays as well as in the staging. The well-dressed hospital will wear plenty of it, judging from the bewildering assortment of fabrics on view—soft, restful shades with delicate self-patterns; also bolder flower designs to cheer the patient. A master stroke in color was applied to uniforms that revealed a complete operating suit in green, with mask and cap to match.

The comfort of the patient seems to be the aim of the mattress manufacturers, as is the assurance to the purchaser that there are long life and satisfaction in present day springs. In one exhibit a heavy roller demonstrated the durability of the construction. In another part of the hall a mattress was displayed in a moving case modernistic in design, revealing the action of the springs.

Shining kitchen equipment attracted the eyes of the administrators as well as those dietitians attending the session on food service. This was not all. The food itself was there, one exhibitor lining up long rows of tempting edibles in individual dishes to whet the appetite of the visitor.

In addition to the commercial exhibits, there were the educational displays, some 43 in all, including that designated as "gadgets," without which no hospital show would be complete. Small wonder, therefore, that the crowds kept going and coming, to take not one look, but many. There was that much to see.

## Contracts With Employees Advocated by Erickson at Administrators' Meeting

Hospitals must eventually make some provision for the old age and unemployment of their employes or they will turn to greener fields, asserted E. I. Erickson, administrator, Augustana Hospital, Chicago, addressing the administration section.

Mr. Erickson advocated a definite contract with the employe that would give a fixed value to perquisites, would specify the length and purpose of vacations and sick leave and would cover other points that might otherwise cause misunderstanding and dissatisfaction. Hospital employes, he said, should have the right to choose leaders and to bargain collectively or, if they prefer, to refuse to enter organized groups and to bargain individually.

Much more emphasis should be put upon the value of perquisites in considering the wages of hospital workers than has been done in the past, according to John N. Hatfield, administrator, Pennsylvania Hospital, Philadelphia. "The public should be shown that Mary Jones of the laundry earns \$40 a month plus 25 meals, free medical and hospital care, certain vacations and holidays, reasonably assured tenure and other types of nonmonetary compensation," Mr. Hatfield added.

In the discussion that followed, Mr. Hatfield was asked if Mary Jones would not be better off if she were paid \$80 a month and bought her own meals. It was pointed out, however, that sometimes it was almost imperative that hospital employes be provided with perquisites.

Hospitals were urged by Frank J. Walter, superintendent of St. Luke's Hospital, Denver, to keep accurate figures on their labor turnover. This is not difficult to do, Mr. Walter said. The number of employes leaving employment each month should be divided by the average total number of those on the pay roll that month to determine the labor turnover.



1. Carl I. Flath, Toronto; 2. Fred M. Walker, Jacksonville, Fla., and James A. Hamilton; 3. Dr. George F. Stephens, Winnipeg, and Graham F. Stephens, Evanston, Ill.; 4. Leon A. Bondi, Galesburg, Ill.; 5. Paul F. Bourscheidt, Peoria, Ill.; 6. I. Craig-Anderson, Davenport, Iowa; 7. Dr. J. Moss Beeler and Paul R. Whitten, Atlanta, Ga.; 8. Kingsley Eckert, Iowa City; 9. Paul C. Elliott, Los Angeles; 10. Dr. George F. McCleary, London, England, and Michael M. Davis; 11. Robert Greve, Ann Arbor; 12. A. W. Dent, Flint-Goodridge Hospital, New Orleans.

## Trustees Told Hospitals Must Reorganize

All records for attendance at a trustees' section of the American Hospital Association were broken in Toronto. Several hundred men and women comprising both trustees of hospitals and their administrators assembled to hear a program that had been months in the making under the direction of David B. Skillman, president, board of trustees, Easton Hospital, Easton, Pa.

It was Mr. Skillman who made the challenging statement that it is the hospital and not the medical man or the government that holds the answer to the demand for adequate medical care at less cost to the individual, at the same time avoiding the socialization of medicine.

Reorganization of hospitals is essential, he believes. Under his plan government participation would be limited to paying dues for the indigent, while the main feature in the change of the hospital organization would be to "make the doctors the faculty of the hospital," each doctor being furnished with his private office and equipment and receiving a salary. In his office he would receive and treat all patients who selected him as their physician, but all bills would be rendered to the patients by the hospital according to a published scale of prices.

What is the ideal hospital trustee? Curtis R. Burnett, president of the board of the Presbyterian Hospital, Newark, N. J., answered this question completely, citing among his list of qualifications—"He must know the administrator intimately, have frequent talks with him, gain his confidence, encourage him to unburden his mind on all problems that he feels are beyond his power of solution, and convince him that he will back him up in every progressive experiment he may desire to try out."

### Small Boards Urged

Carefully selected boards of no more than 12 or 15 members were urged by Raymond P. Sloan, associate editor of *The Modern Hospital*, and trustee of the Methodist Hospital, Brooklyn, N. Y. "Too many of us are involved who haven't the slightest idea of why we are there," Mr. Sloan pointed out. "It isn't unusual to find governing groups comprising as many as 30, 40 or even 60 men and women. Probably one or two are actually doing the work, and the rest are dead wood."

A detailed account of social security legislation as it affects the charitable hospital was made by the Hon. William F. Montavon, Washington, D. C. In considering the contribution that the

hospital may make to its community, the Hon. Henry J. Cody, president of the University of Toronto, stated that already the hospitals of that city were feeling the demands of war. One source of strain, according to Doctor Cody, was the impending scarcity of surgical equipment.

### It Invited Attention

It was a temptation to open the door and walk in, so inviting was the exterior of the little white shop with the show window filled with various soaps and lotions. Many visitors stopped at least to gaze and admire. Just another of the ingenious ways by which a manufacturer sought to present his wares for the benefit of the hospital public!

### Bone Saw Makes Début

Particularly interesting was a new bone saw displayed by one manufacturer because it is sterilizable in entirety. Investigation disclosed the fact that the motor is in a sealed shell that may be sterilized without any possible damage resulting. There is no doubt that it will make many friends before its next appearance at another hospital convention.

## Women's Auxiliaries Hold First Session with A.H.A.

More than \$2,000,000 has been raised in the last twenty-five years by the women's aids or auxiliaries of Ontario and given to the hospitals of that province, according to a statement by Mrs. Oliver W. Rhynas of Burlington, Ont., who is president of the Women's Hospital Aids Association of Ontario.

In addressing a breakfast meeting at which each member of an aid association was hostess to a person from the convention, Dr. Malcolm T. MacEachern declared that the \$2,000,000 given to 100 hospitals in the province was of less value than the tremendous public relations benefits of the women's work. The Ontario organization holds a two day conference every year with approximately 500 or 600 women in attendance.

Dr. G. Harvey Agnew, president of the A.H.A., pointed out that never before had the A.H.A. had a section on women's auxiliaries at its annual convention but that such a section would undoubtedly be a permanent feature hereafter. It was particularly fitting, he said, that this section should be organized in Ontario which had the first province-wide organization of women's auxiliaries on this continent and where organized women's auxiliaries have been functioning with great success since 1865.

## Diets, Purchasing and Dishwashing Are Favored Topics at Dietetic Section

Better for hospitals to cut down the number of beds in these days of rising costs than to reduce the efficiency of diets.

Dr. Frederick F. Tisdall, associate physician of the Hospital for Sick Children and associate professor of pediatrics, University of Toronto, made this statement in discussing the importance of proper diet for treating various diseases. Through the aid of charts and pictures thrown on the screen he showed the need of proper diet for treating scurvy and rickets among children. "You just can't get calcium without milk," he stated.

Look for leadership and educational background in your hospital dietitian was the advice of Ruth M. Park, director of dietetics, Montreal General Hospital. The dietitian should have control of all dietary procedure, including business, medical, nursing and education. Purchasing procedure was outlined by Miss Park; also, the importance of careful checking to assure that goods pur-

chased adhere strictly to specifications. "Above everything else the dietary department should operate on a budget," she stressed.

Dishwashing used to be a woman's job, but now it commands man's attention. Beulah Hunzicker, chief dietitian of Presbyterian Hospital, Chicago, prefers the centralized type of dishwashing. She finds it cuts down duplication of equipment and its control and repair. Too, it is easier to check on one piece of equipment than on several. It actually saves employes working hours, removes noise and clatter from patients' floors and saves floor space.

The mechanical dishwasher is doing the job, according to Miss Hunzicker, and it is a much bigger job today than it used to be, with more dishes on a tray and those dishes more delicate and colorful. A double tank automatic conveyor is an advantage, she believes, with a separate wash and rinse; also a separate hot rinse. Type and size depend on the requirements.

## Trustees' Conference to Meet in Chicago Early Next Year

Plans for a two day conference of hospital trustees to be held in Chicago early next year under the sponsorship of the University of Chicago were revealed at the educational session of the American College of Hospital Administrators.

The A.C.H.A. hopes that this meeting, the first of its kind to be held, will attract wide attendance from the boards of managers of Midwestern hospitals, as well as from Eastern institutions.

At this meeting also reports were made on the various institutes for hospital administrators that have been held in various parts of the country. The Minnesota, Western, New York and Southern institutes have been patterned largely after the Chicago institute, according to the statements made by Ray Amberg, Minneapolis; Dr. B. W. Black, Oakland, Calif.; Dr. Claude W. Munger, New York, and Graham L. Davis, Charlotte, N. C. Gratifying attendance was the general rule and plans are under way for a similar series next year. New England will be added to the list.

## Volunteer Workers Flock to Worth-While Session

"Standing Room Only" was the situation facing many who tried to wedge their way into the meeting of women hospital aids.

That there is a growing place for such organizations in the setup of the modern hospital was the consensus of every speaker; numerous specific examples were cited showing the wide variety of projects in which these groups are engaging.

There must be an atmosphere of complete understanding among the board of managers, the administrator and the aid, E. Muriel McKee, superintendent of Brantford General Hospital, Brantford, Ont., stated, in discussing how the voluntary service can best function in the hospital. It must be put on a sound and systematic basis, she believes, with great care exercised in selecting officers and chairmen. Also there should be no class distinction in auxiliaries. The fees should be low enough to make this possible.

Others contributing to the general discussion were Mrs. Alton Goldbloom, Jewish Hospital Auxiliary, Montreal; E. A. Horton, chairman of the board of trustees, Memorial Hospital, St. Thomas, Ont.; Mrs. Clyde E. Shorey, Presbyterian Hospital, Chicago; Mrs. A. K. Maxwell of the social service committee, Chicago Memorial Hospital, and E. F. Mason, chairman of Nicholls' Hospital, Peterborough, Ont.

## Small Hospital Group Is Urged to Develop Personality of Institutions

No hospital is too small to have a dietitian, if her duties are combined with housekeeping. This combination, according to Vera Clark, dietitian, Guelph General Hospital, Guelph, Ont., will more than pay in the economies achieved. The dietitian of the small hospital should have complete control of her department, maintaining close cooperation with the nursing department as well as with the doctors. It is also necessary that she keep accurate records of food costs. Neatness and orderliness are essential qualifications.

A hospital like individuals can possess personality. The combined personalities of every individual employed constitute the personality of the institution. Unfortunately, as O. K. Fike, managing director of Grace Hospital, Richmond, Va., pointed out, hospitals have been asleep in adopting a public relations program. In speaking of public relations, it is well to remember that any such program must start in the minds of employees of the institution. Too frequently the personnel has not been tied in with community relationship. Mr. Fike believes that: "It is not what a patient pays for and gets that makes him a booster, but what he does not pay for and gets."

Some time try this experiment. Walk in your own hospital grounds as a stranger and up to the front door. Study the exterior of the building carefully, then walk in. What do you see? Take

stock of what you have and make a list of all those things you would like to do. It will open your eyes to needs that you never knew existed. The next step is to get help in your modernization program. The comfort of the patient should be the basis for all plant changes, Dr. A. F. Branton, superintendent, Willmar Hospital, Willmar, Minn., believes. He suggested that the first step should be a study of exterior and entrances. "Try to put life into the impression one gets of the exterior," he urged. Then comes the reception room. Incidentally, have you any small rooms adjoining or in close proximity in which visitors who desire privacy can retire? These should be attractively furnished and made comfortable for those who have lost relatives or friends. Certainly, patients' rooms deserve careful thought. Doctor Branton wondered why more attention is not paid to the treatment of ceilings. Finally, there are the many specialty rooms. "View your hospital through the eye of a friendly critic," he advised.

What not to do in laying out a small hospital was related by C. F. Golden, superintendent of Lee County Hospital, Sanford, N. C. This discussion took the form of an actual demonstration of plant construction. Similarly demonstrated, was the importance of a good accounting system in the small hospital, presented by Gordon A. Friesen, superintendent, Belleville General Hospital, Belleville, Ont.

## Thinks Tax-Supported and Voluntary Hospitals Must Work Together

Desirability of governmental and voluntary interests combining to meet the hospital needs of the community was stressed by Margaret P. Plumley, New York, in a discussion of governmental or tax-supported hospitals. Would it not be better, Miss Plumley suggested, in communities not having proper hospital facilities to provide hospitalization either under governmental or under voluntary auspices that would meet the demands of all types of patients whether indigent or not? Also would it not be better to substitute for several small hospitals inadequately equipped and staffed one good hospital conducted either under government or voluntary control? Would not physicians be able to provide better service because of better facilities?

A problem facing those in charge of tax-supported hospitals is making collections from those who are able to

pay. Frequently, because of being taxpayers, patients who are able to pay for their hospital service try to get it for nothing. The cooperation of city officials in combating this tendency has proved of help.

The question of whether health departments and hospitals should continue separately or should operate in closer coordination was discussed by Dr. Joseph W. Mountin, Washington, D. C. It is more urgent in rural areas than in urban communities that they be brought together under the same roof or at least in close proximity.

Personnel problems with relation to civil service and governmental restrictions were outlined by George P. Bugbee, superintendent, Cleveland City Hospital. The city hospital as a teaching unit of the medical school was presented by Dr. Walter S. Goodale, superintendent, Buffalo City Hospital, Buffalo, N. Y. The Rev. Alphonse M. Schwitalla, dean of the medical school, St. Louis University, described the place of the governmental general hospital in the hospital field.

## A.H.A. Asks Cooperation of A.M.A. in Inaugurating Low Income Insurance

The American Medical Association was again invited to join with the American Hospital Association in working out and inaugurating plans for hospital and medical service to patients of low income in a resolution adopted by the house of delegates.

The resolution, introduced by Dr. Basil C. MacLean on behalf of the Commission on Hospital Service, reviewed the action taken last year at Dallas and the favorable response given by the American Medical Association and called attention to the still greater urgency of solving this problem today.

Last year there were approximately 2,000,000 subscribers to hospital care insurance plans while this year the number is approximately 4,500,000. Yet the growth of the plans and further study of membership coverage suggest that there are still considerable groups of the population that need more assistance in meeting the problem of costs for hospital care and associated medical service.

In some instances, the statement pointed out, such low cost plans could probably be entirely self-supporting but in others aid from charitable funds or public monies might be necessary.

An extensive report on the research program and information service of the council on hospital service plans was presented by C. Rufus Rorem. This program is financed by voluntary assessments on the part of the plans and funds to date have more than equaled expenditures. Extensive work has been done on accounting and office procedure, actuarial data, statistical compilations and reciprocity.

Vigorous discussion was occasioned by a statement in the report of the council on hospital service plans that "the relationship between hospitals and commercial insurance companies be limited to ordinary requirements of credits that would be established for other hospital patients." Guy J. Clark of Cleveland objected to this statement as being vague and perhaps decidedly unfair to patients who had taken out insurance in commercial plans. The delegates voted to strike it from the report.

### Library Gets Nightingale Bust

A bust of Florence Nightingale was presented to the library of the American Hospital Association by Dr. Joseph R. Morrow, administrator, Bergen Pines County Hospital, Ridgewood, N. J. The handsome bust, carved of wood, was the gift of Doctor Morrow.

## Federal and State Legislation Is Large Concern of Protestant Group

The tremendous importance of federal and state legislation to the church hospitals of America was emphasized in the report of the legislative committee of the American Protestant Hospital Association presented by Arthur M. Calvin, executive secretary of the Minnesota Hospital Service Association of St. Paul.

Mr. Calvin reviewed the history of the Wagner Health Bill and quoted extensively from the testimony of Bryce Twitty presented on behalf of the American Protestant Hospital Association. It was stated that the new federal security commissioner, Paul V. McNutt, is planning to throw strong support behind the bill and to make it the principal aim of his administration.

Attendance of 179 at the Protestant meeting was greatly in excess of the attendance at other recent conventions of this organization.

The wide scope of work of the church hospitals in the United States and Canada and throughout the world was presented in a summary paper by Newton E. Davis, executive secretary of the board of hospitals, homes and deaconess work of the Methodist Church. In his survey, Doctor Davis found that there are 378 Protestant hospitals in the United States and 42 in Canada and 694 Catholic hospitals in the United States and 212 in Canada. The Jewish church, he reported, has 31 hospitals in the United States and Canada.

The Protestant hospitals have 40,072 beds in the United States and 2914 in Canada; the Catholics have 85,214 beds in the United States and 36,468 in Canada, while the Jewish hospitals of the United States and Canada provide a total of 10,152 beds.

"The church hospitals in all lands are in duty bound to practice the highest ethical standards in all of their work and service," Doctor Davis declared. In his tabulations he pointed out, however, that a considerable number of the church hospitals have not yet been fully or provisionally approved by the American College of Surgeons.

A hospital public relations program affects every activity within the hospital walls, according to A. J. Swanson, administrator of Toronto Western Hospital, in a round table on public relations conducted by Alden B. Mills, managing editor of *The Modern Hospital*. Mr. Swanson pointed out that every contact with patients, with visitors, with personnel has a bearing on the eventual relations that a hospital

### A.P.H.A. Officers

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is able to establish with the community.

The wisely directed public relations program today is one that is designed to promote the welfare of all hospitals rather than the selfish interests of any one, Mr. Swanson declared.

The place of the expert in a public relations program was warmly debated during the round table, some persons contending that fund-raising firms could not be as successful as local people because they do not know local situations, while others stated that fund raising was a technical process requiring special skills comparable to those of a surgeon or an engineer. The consensus was expressed by Oliver G. Pratt, administrator of Salem Hospital, Salem, Mass., who said that local conditions varied so that no one answer could be given to the problem.

### Social Security Money for Aged Sick

Steps to develop a method whereby state and federal funds can be made available to pay in full or in part for the hospital care needed for acute illnesses among aged persons who are beneficiaries of the Social Security Act were taken at the Toronto convention. On a suggestion by Guy Clark of Cleveland the matter was referred to a committee to explore and to develop a plan. Mr. Clark reported that Arthur J. Altmeyer, chairman of the Social Security Board, had already expressed himself favorably toward the idea in principle.



1. Dr. Jacob Prager and Dr. Morris Hinenburg, Brooklyn, N. Y.; 2. Clyde L. Sibley, Birmingham, Ala., and Dr. A. M. McCarthy, Electric Mills, Miss.; 3. Dr. W. P. Gardner, Anoka, Minn., and Dr. T. E. Broadie, St. Paul; 4. Donald Smith, Hanover, N. H.; 5. Dr. G. Harvey Agnew; 6. E. R. Crew, Dayton, Ohio; 7. Thomas F. Clark, San Francisco; 8. Mary L. Elder, Burlington, Iowa; 9. J. S. Williamson, Saskatchewan; 10. A. Langehaug, Fort Dodge, Iowa; 11. O. K. Fike, Richmond, Va., and A. E. A. Hudson, Dallas, Tex.; 12. Esther B. Morgue and E. L. Slack, Samuel Merritt Hospital, Oakland, Calif.

# "World Unity" Is Theme of Convention That Never Met

## Urges Pocket Case History

A health card for every citizen was recommended in the report on the admission and distribution of patients prepared by the committee on functional conditions of hospital architecture.

"Just as the school child has his school report, the traveler abroad his passport, the militiaman his service book, so every citizen ought to have a health card, a 'pocket case-history' or whatever you like to call it.

"In this record should be found not only brief biological facts as to his heredity but short notes about his condition of health. This is the central register in which the family doctor, the specialist, the school doctor, the sports doctor and, later, the army doctor and the hospital doctor should make their entries."

Dr. B. Albert has introduced a model health card in Zlin and it has already proved its value. In order that the objection could not be raised that it was contrary to medical secrecy, the card used at Zlin is in Latin and the medical entries are made in Latin."

## You Must Go to Cairo to Visit the Largest Hospital in the World

The largest hospital in the world both from the point of view of floor space and number of patients served is the Fuad the First Hospital, Cairo. Under the guidance of one of Egypt's most eminent surgeons this hospital has, within a single decade, become the principal hospital in the Middle East. So Dr. Paul Ghalioungi of Heliopolis, Egypt, would have told the I.H.A. convention had he been present and had there been a convention.

Doctor Ghalioungi, however, does not think that surgeons, except in exceptional cases, should head hospitals. The more a man delves into a special branch of medicine, the more he tends to neglect the wider aspect. The control of a hospital had best be vested in the internist, in the report of Study Committee XXIV, headed by Doctor Ghalioungi.

During the World War period, owing to the overwhelming number of surgical emergencies the control of the hospital in many cases passed from the physician's into the surgeon's hands, and since then the habit has persisted in many places, the committee report

By Mildred Whitcomb

This is a report of the strangest convention in the history of the International Hospital Association, the convention of September 1939, the convention that never convened.

If its conscientious planners had, on wakeful nights, sometimes worried lest an argument on the convention floor might uncontrollably turn nationalistic or racial or personal, they need have lost no sleep. This Toronto International was by all odds the calmest, least controversial affair on hospital record.

On the morning of September 19 the convention chambers of the Royal York Hotel gave forth not the slightest inharmonious sound. Interpreters who, through microphones, were to give the addresses of platform speakers to each ear-phoned delegate in his native language had been waved away by the convention committee, but the hospital administrators from Poland and Germany, from France and England and Russia, from Belgium and Italy and Hungary gave no sign that arrangements were awry. There they sat on little gilt chairs, these phantom delegates from overseas, in silent attendance upon the opening address of their president, a man who appeared strangely troubled and grave.

"World Unity in Relief of Suffering," intoned President Malcolm T. MacEachern, striking the convention keynote.

"World Unity, World Unity," responded a choir of 300 little gilt chairs.

"Relief of Suffering, Relief of Suffering," chanted the crystal chandeliers.

"World Unity in Relief of Suffering," that was the theme song of the convention that never came off.

Because the 1939 international convention committee, in direct defiance of all threats to World Unity and to Relief of Suffering, had compiled one of the strongest programs ever to be presented to a hospital assemblage, The MODERN HOSPITAL begged permission of President MacEachern to be allowed to cover the convention that never came off, to prepare a report from official papers presented in advance.

If this coverage of ours seems devoid of color, remember that these convention papers were heard only by a spirit gathering. Remember, too, that within the month our minds have become accustomed to grimmer sensations, to bombs blasting World Unity, to guns inflicting suffering in a world where suffering has never yet been half relieved.

states. The majority of these hospitals became mere operating theaters with waiting and convalescent rooms attached. The specialist was far too busy improving his operating technic to pay sufficient attention to the details of administrating the hospital.

## Decorate Some Rooms to Stimulate; Others to Soothe

Vary the color scheme of patients' rooms, suggests I.H.A. Study Committee XXII. Decorate some rooms in bright colors to stimulate patients that need stimulating. Choose subdued tints or shades for others where a sedative reaction may be desired.

So long as the entire decorative scheme is in harmony, it is possible to provide a wide range of choice in individual rooms.

This change of pace can best be obtained through draperies.

In general, heavy draperies are allowable in brilliantly lighted rooms, while for rooms that are naturally dull the draperies should be selected to relieve this dullness.

## "Sheer Barbarism" to Awaken Patients Early in Morning

A thorough examination of hospital service from the standpoint of the patient was made by Committee VI, of which Dr. W. Alter of Buchschlag, Germany, was chairman. Doctor Alter is also editor of *Nosokomeion*, the journal of the International Hospital Association.

Greater attention should be paid to the psychic effects of patient treatment, the report declared. Irreproachable hygienic conditions, absence of disagreeable odors, maximum provision for comfort and rest, satisfactory feeding, treatment as individuals, friendliness, harmony among hospital employes, comfortable conditions in examining rooms, good social service work and a well-equipped library were among a few of the many factors emphasized in this study committee's report.

The awakening of patients at 5 a.m. was called "sheer barbarism" and strongly deprecated.

## Recommendations for Modernization by Hamburg Architect's Committee

A rationalized general plan for the whole hospital service of an area should be drawn up before a decision is made to modernize an old hospital, according to the report of Study Committee I under the chairmanship of Hermann Distel, architect of Hamburg, Germany.

Such a plan should take into account any alterations that may be called for in coming years owing to population, public health and economic developments of the district and should be kept in harmony with actual developments.

With such a plan the hospital authorities and the architect are in position to decide more advantageously whether an old building should be remodeled or an entirely new building constructed.

"Reconstruction of the old building," Chairman Distel warned, "is only permissible if the old and new portions can be reconciled into one useful economic and esthetic unity in such a way that the reconstructed establishment can satisfy all essential requirements of modern medicine and science and can be maintained in that condition at normal costs for a fair space of time."

The committee pointed out that one of the most cogent arguments for rebuilding or replacing old buildings was to effect better arrangement of internal traffic. "It is absolutely essential, if the hospital is to function without friction or disturbance, that the circulatory system for in-patients and out-patients, visitors, staff and domestic traffic be kept separated from one another. For all domestic traffic an endeavor should be made to create a special transit route, possibly below ground level, with lifts to the ancillary rooms, to the wards and, if need be, with subways to the kitchens, laundry and disinfecting room."

In the second section of this committee's report dealing with hospital windows, doors and floors, it is recommended that the total minimum window surface of a hospital ward be from one fifth to one seventh of the floor space in wards of several beds and two square meters in single rooms. There is no maximum although the greater the window space the greater the heat and noise penetration.

Use of metal frames for large windows or for windows exposed to steam is recommended. "Actually bronze windows are now recommended as more economical in the long run, in spite of their high initial cost," the

committee states. For fittings bronze, hard white metal and artificial resins are suggested.

Floors for hospital purposes, the committee states, should be good wearing, nonconductive of sound, elastic, warm, water-resistant, as seamless or jointless as possible, durable at small upkeep cost, easy and cheap to clean.

### Supremacy in Hospital Equipment

Kitchen equipment in the newer European hospitals is designed with greater precision and superior design than will be seen in other parts of the world, states Edward F. Stevens, Boston architect. On the other hand, the laundry, the x-ray and the sterilizing equipment of the United States hospitals is superior to any in the world.

### Half Wool Blankets Satisfactory

For ordinary hospital use, the 50 per cent wool blanket is satisfactory and shows a lesser tendency to harden when washed. For some special uses, a higher percentage of wool is desirable. So reports I.H.A. Committee XXII.

## Fashion Decrees Wooden Beds or Iron With Synthetic Finish

Fashions change in hospital as well as in home furnishings. For a long period the wooden bed was out, so far as institutional use was concerned. Wooden beds are now being used extensively, particularly for single and double rooms of the better type. New finishes prevent marring.

The finish of the iron bed is of extreme importance, according to I.H.A. Study Committee XXII. No enameling process has been discovered that will prevent chipping and nothing ruins the appearance of a hospital ward more quickly than mottled bedsteads.

The old style baked enamels are being replaced by the newer synthetic finishes. They withstand chipping to a marked degree.

### Urges a Room for Each Patient

A room for each patient is not an unattainable optimum in the opinion of Dr. Ing. Gaspare of Lenzi, Rome. It accomplishes the goal of the highest good for the patient and it causes neither inconvenience nor increased operating costs. It may entail a slightly higher constructional cost but, in time and with an increased number of such buildings, designs will be improved and worked out at lower cost.

## Lists Advantages of Panel Heating

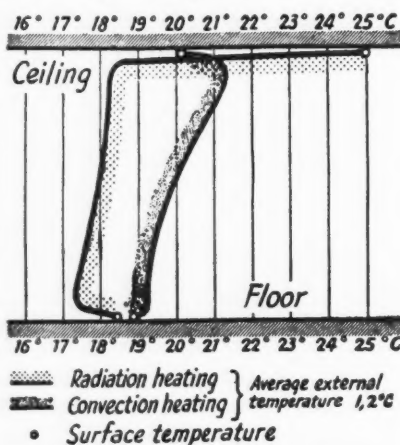
Radiant heating through hot water pipes embedded in ceilings was strongly recommended by Committee II headed by Dr. Ing. habil. Adolph Heilmann, Berlin-Charlottenburg, Germany.

Panel heating in both operating rooms and wards causes a more pleasant warming of the human body than indirect convection radiator heating, the committee declared. A study made in 44 English hospitals that have em-

ployed panel heating from one to twelve years indicates that there were no injuries to ceiling surfaces when the embedded pipes were properly installed and that the panel heating had the following advantages:

1. Floor and wall spaces are left free for furniture.
2. There is less demand for cleaning.
3. Heat is regularly distributed and heat transmission is not obstructed by furniture.
4. Air borne infections are reduced because air currents are reduced.
5. There are less dust accumulation on the heating surface and less possibility for the growth of bacteria.
6. Walls and ceilings are not blackened through rising warm air currents.
7. Higher standards of comfort are provided at lower air temperatures.
8. Direct warming of the patient through heat radiation of low temperature results in less "dry" air.
9. Natural ventilation can be used without discomfort.

In open wards a temperature of about 53° F. can be used when the outside air is at freezing.



The dotted line shows the vertical course of the temperature in rooms heated by radiators placed under windows.

## Bath Tubs v. Showers Is

### Argued by Study Committee

Bath tub v. shower is always a good question for argument wherever hospital men gather. I.H.A. Study Committee XXII seems to throw the weight of its evidence toward the tub, although it speaks a good word for the clear tile shower that is well lighted and has no corners or rough places in which infections may lurk.

Access to the bath tub should be from three sides at least, the committee recommends. The tub should be acidproof and have a drain at the bottom. Many patients not strong enough to stand under a shower may sit in a tub. Grips should be provided to help the patient get in and out.

If showers are used the shower head should be placed so that the hair does not get wet; control valves should be accessible without the necessity for exposing the hand or arm to the stream of water, and there should not be a sufficient number of showers on any one riser to produce sudden pressure fluctuations which result in quick changes of temperature. There is no absolutely reliable thermostatic valve for showers, in the committee's judgment.

## Paris Architect Favors

### Use of "Roundpoint" Plan

Doing away with useless space increases the efficiency of the hospital and the comfort of the patients and represents immense financial savings.

M. Jean Walter, Paris architect, has attempted to do this in Beajon Hospital, Paris, and in the hospitals at Lille, France, and Ankara, Turkey, by two means: (1) bringing together on one floor all the ward and consultation sections for each particular department, and (2) hunting out any pieces of building that could be dispensed with, particularly cutting corridor space to a minimum. Corridor space has been eliminated by the following arrangements:

The center of each hospital department is formed by an elliptical "roundpoint" toward which all wards converge and around which are arranged rooms for meetings, lavatories, lifts for patients, other lifts, offices for the distribution of food and medicaments with their own lifts, and a lift for removing the dead.

In the center of the roundpoint is placed another ellipsis, in which are accommodated the head sister and her staff. This ellipsis is marked off by offices in which are stored stocks of linen, medicaments, dressings, warming cupboards and refrigerators.

## Teach Cooks How to Use Electricity

Many cooks have not yet learned how to utilize effectively the new electric ranges now available, according to Marion Ffoulkes-Pritchard of Boksburg, Transvaal, South Africa, who heads the I.H.A. committee on electrical equipment in kitchen, laundry and stores.

"An intelligent use of electrical stoves and appliances is essential to their economical and successful use and it is no uncommon thing to find electrical cooking apparatus fitted correctly with heat regulating switches but employed continuously at full heat, temperature

being affected by the older method of opening oven doors and ventilators. This, of course, entirely destroys the economy peculiar to the electric method and introduces into the kitchen many of the disadvantages of the older method. It often creates a bias against electric cooking quite unjustified and difficult to displace."

In concluding her report, the chairman stated that electrical equipment in kitchen, laundry and stores of the hospital is playing no small part in the institution's economics and progress and in the welfare of the patient.

## What Department Should Care for Sick and Premature Infants?

Should sick and premature infants be cared for at the pediatric clinic or at the obstetric clinic?

Expert opinion differs. Prof. Dr. Frans Daels, director of the University Hospital for Women, Ghent, Belgium, considers that the care of sick and premature infants at the pediatric clinic has such great advantages that one must accept the inconvenience of the regular transport once or twice a day of the mother's milk from the obstetric clinic to the pediatric clinic.

Prof. N. Louros, chief of the maternity hospital of Athens, Greece, holds that it is better to keep the ailing infant at the obstetric clinic as long as the mother remains there and to call on the help of a specialist from the children's clinic to direct the treatment.

## Asks That Hospital's Rights Be Defined by Legislation

A code of hospital law in each country was called for in a report of Committee V, headed by Dr. J. Oster of Strasbourg, France. Public authorities are entitled to assume four powers, the committee stated: (a) intervention when new hospitals are being created, (b) definition of the hospital's sphere of action, (c) supervision of how the hospital is run and (d) regulation of the hospital's relations with local authorities and other bodies.

For nongovernmental hospitals the regulations will be simple and few, according to the committee's ideas, but for governmental institutions they would be more detailed and thorough.

To reduce the public liability of hospitals, the committee suggested that the rights of the hospital in regard to necropsies, burial, the property of the

patient deposited with the hospital, professional secrecy, work done by the patients, arrangements for religious observances and similar matters be defined by law.

## Mass X-Ray Examinations

### Possible by Indirect Process

A new process of indirect x-ray examination by means of photographs of the screen image on a small photographic film was to be presented for discussion at the Toronto meeting by Prof. Dr. Hans Holfelder of Frankfurt-am-Main, Germany.

The advantages of the process lie in its great economy of photographic material while its disadvantage is the lack of sharpness in the fluorescent screen image and, therefore, the difficulty of recognizing the finer line structures, the Study Committee states. The process has already proved its worth, according to the committee, in the making of serial x-ray exposures aimed to discover the presence of tuberculosis, dust diseases and heart diseases. The process has already found partial entry into hospitals for verifying the locations of bone fractures and splinters.

Because of the inexpensiveness of the process, mass examinations can be made for public health purposes, even covering the entire population of an area if desirable.

## Ideal Hospital Bullet Shaped

The ideal hospital from the standpoint of convenient service would be bullet shaped.

In the center of the bullet would be the central treatment and the domestic departments and at the circumference of the bullet would be the nursing units, with the ward kitchens, bathrooms and other service rooms ranged along the radius in each case.

## Working Agreement Between Clergy and Hospital Authorities

Practical considerations in the spiritual care of the sick were outlined by Study Committee XVII in the report prepared for presentation in Toronto. Physicians are coming more and more to recognize the body and soul as parts of an inseparable whole, the report prepared by Pralat Dr. Kreutz of Berlin stated.

To obtain cooperation between ministers of religion and hospital authorities, certain fundamental conditions must be observed by both parties:

1. Mutual respect and appreciation and acceptance of each other as equal partners, equally effective in the healing of disease.

2. Consideration by hospital authorities of the peculiar qualities and independence of action of each religion.

3. Free access to patients by ministers of all denominations.

4. Full support and help for ministers from administrators.

5. Information regarding the religion of each patient and ample time for visitation at a period when this will be most effective for the patient.

6. Facilities for religious rites at the bedside, a room for private talks, use of the telephone, participation in the stocking of the hospital library and in the organization of entertainment for patients.

7. Understanding help from the nursing staff.

8. Adaptation by the minister of his methods to the special conditions found in hospitals.

9. Tact, skill and diligence on the part of the minister in the performance of his duties; avoidance of any interference in the necessary routine of the hospital.

10. No interference by the minister in matters that do not concern him, such as staff matters, domestic arrangements and deficiencies in hospital organization.

## Follow-Up of Patients Has Public Relations' Value

The best publicity for hospitals is the praise of satisfied patients, declared Study Committee XV in its report on press and publicity. The committee then proceeded to list a variety of ways in which hospitals can more surely win such praise.

Among suggestions prepared by the chairman, Dr. A. Barthelme of Stras-

bourg, France, is the one that the contact with the patient should not end when he leaves the hospital.

"It is not right that the patient should from the moment of his discharge consider that he has lost all interest in the establishment where he has been cared for. Contact should be maintained by follow-up examinations, by information on his condition being sent to the doctor who treated him and also to a visiting nurse, by sending nurses, if need be, to the home."

## Asks General Hospital Men to Help Detect Schizophrenia

Urgent requests that general hospitals take a more active part in detecting and treating cases of schizophrenia, which is estimated to afflict more than 4,000,000 of the 2,300,000,000 people inhabiting the globe, were voiced by the committee on psychiatry headed by Dr. Thomas J. Heldt of Henry Ford Hospital, Detroit.

"During the past ten years," the committee stated, "far-reaching advances have been made. The many facilities for examination and treatment, as found in the general hospital, should be made more readily available for the examination and care of the mental patient. The meagerly manned state and national institutions may be ever so willing to investigate and to administer to the problems of schizophrenia but they are too heavily burdened for truly successful work."

## Special Instructions Needed for Handling Head Injuries

Head injuries from traffic and industrial accidents are increasing so rapidly that much closer cooperation is needed between surgeons and neurologists in general hospitals, where most of the accidents are treated, declares Dr. F. H. Lewy of Philadelphia.

"In many of these hospitals a trained neurosurgeon is not yet available. Therefore, in every hospital an outline should be accessible indicating the standard examinations and procedures to be applied in various conditions of head injuries.

"Much more rapid readjustment of patients following head injuries and prevention of undesirable sequelae can be established by psychic and physical first aid and by adequate methods of treatment. Specialized neurological rehabilitation centers should be instituted in conjunction with the neurosurgical department of some large hospitals in each state."

## Says Voluntary Hospitals Must Unify or Disappear

Voluntary hospitals cannot much longer exist unless they are willing to submerge their traditional conception as a number of independent units without any clear-cut comprehensive program of service deliberately planned and operated according to ascertained needs and available resources, boldly declared Capt. J. E. Stone, as chairman of Committee III.

Captain Stone is consultant on hospital finance to King Edward's Hospital Fund for London and is author of several books on hospital administration.

The committee declared that the present system of hospital service is inadequate, inefficient and uneconomical. The haphazard growth of hospitals has resulted in a miscellaneous collection of voluntary hospitals, clinics, dispensaries, municipal general and isolation hospitals, sanatoriums, mental disease and lying-in hospitals and various other special hospitals dotted about without any regard for needs.

"We consider that the problem can be solved," the report stated, "only by the abandonment of the principle of individual units and the adoption of a scheme for the systematic organization, planning and development of such hospitals as are required to form an adequate and economical service under unified control."

The committee took care to point out that rationalization does not mean nationalization but rather will delay or indefinitely postpone the taking over of voluntary hospitals by governments.

Rationalization "calls for the closing of a number of hospitals and the amalgamation of others; it calls for the submergence of personal and institutional interests; it calls for unification."

## Hospitals Must Play Second Fiddle

The primary interest of the International Hospital Association (and all hospital associations) should be health or disease elimination.

Disease-curing should be the secondary interest.

This point of view was the main contribution of Architect Charles E. Elcock of London in his I.H.A. convention paper. Cities should glory in their community halls, parks, swimming baths, gymnasiums, schools and their preventive health centers, the hospital becoming a secondary and unfortunate necessity, he believes.

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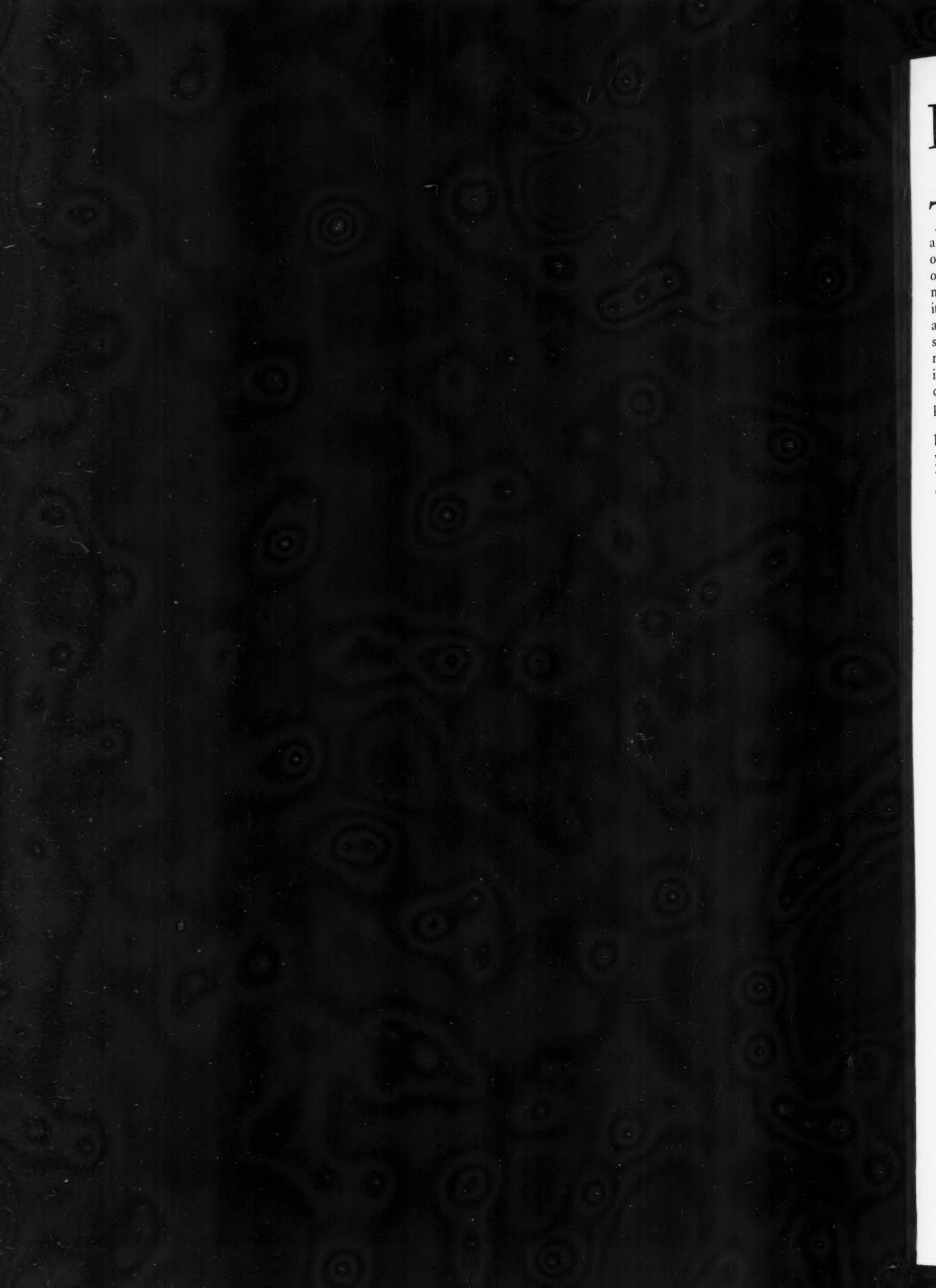
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# Employment Diagnosis

WINIFRED McL. SHEPLER

THE human material of which an organization is composed has a good deal to do with whether the organization fulfills its purpose well or badly. Alert modern hospital administrators, convinced of the validity of this principle, are placing more and more emphasis on the careful selection of this material and on making the most intelligent use of it in building sound organizations that can be counted on to fulfill their purpose satisfactorily.

The City Hospital of Cleveland has been experimenting for two years with methods of deciding which of the many applicants for employment are most likely to become assets to the organization. To the casual observer there might seem to be little choice among these candidates. The correct employment diagnosis depends on the employer's skill in perceiving individual differences and in discriminating between more or less similar qualifications.

The staff member who conducts the employment interviews should be a person who senses what an ordeal the experience may be for the applicant. In these days of economic insecurity a job may mean life itself and anyone who has the fortitude to continue to seek work against tremendous odds is certainly entitled to courteous, thoughtful consideration.

## Misfits Eliminated

In initial interviews there can always be a certain amount of immediate elimination of the conspicuous misfits. The employer who is observing and alert to identify disqualifying attributes conserves time and application forms by tactfully discouraging formal registration of these aspirants. In the most understanding and kindly way they may be first commended for their courage in seeking work and then told gently but firmly that they cannot be considered for employment, and why. This method is much fairer than the easier but less honest method of telling job-seekers who would not be considered at any time to "come back

next month" or of dismissing them with no explanation.

The next screening process is on the basis of questions involving general policies of employment, such as insistence on American citizenship, residence within the city proper and certain minimum educational requirements. Finally, only those who survive these eliminating processes and who appear to be suitable for hospital employment physically, mentally and personally are permitted to fill out the application for employment form.

The interviewer's skill in the swift review of the application form increases with use; any unusual situation is readily discernible, such as discrepancies between the birth date and the given age or between the birth date and the years of leaving school, or a difference between the applicant's name and address and that of the nearest relative, suggesting an alias or a broken home.

The school history as recorded is especially significant; for instance, a little rapid arithmetic will reveal any wide variation from the usual pattern in which a child enters school at 6 years, completes the grade school (sixth grade) at about twelve years, junior high school (ninth grade) at about 15 years, and senior high school (twelfth grade) at 17 or 18 years. Retardation in school progress is usually indicative of either mental inferiority, emotional instability, psychopathic personality or chronic illness, any one of which would disqualify the applicant for most hospital positions.

This brings us to a discussion of the applicant with the high I.Q. who is willing to accept "anything" in the way of a job. Some authorities maintain that it is unwise to place an ambitious, mentally superior person in a menial position below his level, on the theory that he will feel frustrated and be discontented there. Others, however, have found that this type of employe brings much needed intelligence to his group and that he

usually accepts the routine with good grace while using the job to further his ambitions for a higher education outside of hours. At the City Hospital in Cleveland, college, premedical and medical students are being used with notable success as orderlies, ward aids, members of the kitchen crew and in the laboratory.

By law in Ohio children must remain in school until 16 years of age, and since, with normal progress, they should have completed the tenth grade by that time, this grade has been set as a minimum educational qualification for all ward workers at City Hospital.

Verification of the school record is always desirable, and the Cleveland schools have been most cooperative in responding to a form letter. Frequently, helpful comments are added by the teachers, usually recommending, sometimes discouraging hospital employment for their former pupils.

## Employment Record Important

The employment history is, of course, particularly significant, but it is necessary to keep in mind that the boy or girl who is a product of the depression years almost never has a record of steady employment dating from the time of leaving school, such as used to be the American ideal. The usual story now is of a few weeks in one industry, a few months in another totally unrelated field, a long stretch of idleness and a brief try at something else. The "reason for leaving" is important and a series of experiences in "quitting" is a danger signal.

At City Hospital experience has proved that what a potential employe has actually accomplished in employment is not so important as what he can and is willing to learn to do. A capacity for adaptability is more essential than any amount of previous experience.

Character references from a family physician, a pastor or priest, a favorite teacher or a well-established

Miss Shepler was formerly personnel director of City Hospital, Cleveland.

The City Hospital of Cleveland, while attempting to develop a more satisfactory employment system, has also established a practical individual

1. Face sheet.
2. The application for employment form.
3. Correspondence relating to school history, employment history, character reference.
4. A chronological record of all contacts at the personnel office with or about employes.
5. The appointment form, signed by the department head, signifying acceptance for employment.
6. Correspondence with the local civil service commission.
7. Other correspondence (for instance, concerning indebtedness).
8. Carbon copy of transfer form (indicating transfer from one department of the hospital to another).
9. Carbon copy of change-of-pay form (indicating promotion, demotion or other change of maintenance status).
10. Leave of absence form (signed by the department head, signifying that permission was granted).
11. Termination of service form (signed by the department head).

The face sheet is the most recent addition to the personnel folder. The upper third of the face of this form is a replica of the accounting office card. The duplication of recording of such information as date of appointment, position, pay status, transfers and termination of service is necessary because in an organization of 1300 employees it is essential that all information concerning an employe be available in one place. Also, it enables the personnel office to assemble any required data regarding the staff members without disturbing the accounting office cards, which may be needed for pay roll purposes. The record of training courses and the efficiency record on the reverse side of the form are intended to supplement the statistical data and

Form 13a 2-78-129

**CITY HOSPITAL**  
CLEVELAND, OHIO  
**PERSONNEL DEPARTMENT**

## APPLICATION FOR EMPLOYMENT

**CITY HOSPITAL**  
CLEVELAND, OHIO  
**Personnel Department**

### Service Record

Name		(Last)	(First)	(Middle)	(Maiden)
Address		Date of Birth		Age	
How long has this been your address?		Sex		Color	Religion
Phone		Single		Married	Wid.
How long have you lived in Cleveland?		Parent or		Div.	Sep.
Are you an American Citizen?		Nearest Relative		Address	
If not, have you applied for Citizenship?		Are you related to any person employed by City Hospital or City of Cleveland?		Name and Position	
Nationality of Parents:		How many persons are dependent on you?		Totally	
Father		Mother		Partially	
Have you ever been employed at City Hospital?		Explain nature of dependency		When?	
Where?		Education:		College or Business College	
Grade School		Jr. High School		Sr. High School	
Name of School					
Location					
Years Attended					
Last Grade Completed					
Year left school					
Average grades					
What subjects do you find most interesting?		Most Easy?		Most Difficult?	
If you have taken University Work what was your major field?					
Remarks:					

[illegible]

to round out each individual employee's record of preparation and experience within the organization.

The value of this form is that it summarizes for ready reference each employee's entire work history in the organization. In matters pertaining to civil service status, to retirement system privileges and to seniority rights in consideration for promotion or in lay-offs, this information uniformly recorded for all classes of employees is invaluable.

The application for employment form is in use practically in its present form in at least one other large general hospital. It has proved satisfactory in Cleveland after a year's trial.

Correspondence relating to school history, employment record and character references may be simplified by the use of form letters that have been found to elicit satisfactory responses.

#### **Records Should Be Objective**

The chronological record of contacts at the personnel office with or about an employee is typed or written on letter-size plain paper, giving a brief resumé of service rendered, after the manner of a social case-history record. Grievances of employees, requests for transfer, complaints by supervisors and appeals for help with family or personal problems all contribute to the total picture of the individual and his work adjustment. Conservation of clerical work requires that these notes be brief and concise, summarizing the service asked for and what was done about the situation. Care should be taken to keep these recordings as objective as possible, eliminating gossip and other irrelevant matter.

The appointment form is given to the applicant selected by the personnel office when he is sent to the department head for interview. The final decision regarding employment rests with the department head. If the candidate is approved, the department head sends him back to the personnel office with the signed form indicating when he is to report for duty. If he is not approved (which fortunately rarely occurs), the candidate is told that he will be communicated with later, and the appointment form is returned to the personnel office through the hospital mail with the reason for rejection stated on it. When this form is duly

signed by the department head it is the personnel office's authority to make out the complete set of personnel forms, including the employment card, placing the new employee on the pay roll.

Correspondence with the local civil service commission is conducted by means of form letters, copies of which are retained in the personnel folder for each employee.

General correspondence concerning employees usually relates to delinquent accounts. A routine reply, but not a form letter, informs the creditor that the employee has been notified of the correspondence by his department head. No further responsibility is assumed by the hospital in these cases.

A carbon copy of the transfer form is kept on file as a check against the accounting office to which the original is sent. The new position is posted on the face sheet from this form.

A copy of the change-of-pay form is retained in the personnel file as a check against the accounting office and it is from this carbon that any change of pay status is posted on the face sheet.

The leave of absence form was created for the use of the department heads in notifying the personnel office of all contemplated leave, extension of leave and return from leave. This is necessary because the personnel office is responsible for notifying the local civil service commission of all leaves that cover an entire pay period.

#### **Termination of Service**

By means of the termination of service form the department head notifies the personnel office when an employee is to leave the service. Usually this is preceded by a telephone conversation during which the reason for termination and plans for replacement are discussed. The personnel office usually interviews each outgoing employee and tries to prevent regrettable voluntary resignations whenever possible. This form is also used for posting on the face sheet the date of leaving and the reason.

The certificate of employability signed by the examining physician is filed to record that the employee has satisfactorily passed a physical examination, has had a chest x-ray

and a Kline test for syphilis and has been immunized against smallpox and typhoid fever. In compliance with public health regulations a special form is executed for all food handlers.

The job analysis sheet concerns only those employees who have remained on the staff since a survey was made in 1937. A description of their duties in the employees' own words might be a desirable supplement to the material in the folders of all staff members.

Newspaper clippings concerning anyone identified as an employee, past or present, are filed with his record, whether the material relates to his particular work or not.

#### **System Saves Money**

Hospital administrators may raise the question whether this process of making a correct employment diagnosis and of keeping adequate personnel records is not prohibitively expensive. The City Hospital of Cleveland believes that it has demonstrated that in the long run this system will save any institution money. The process of frequent "hiring and firing" with consequent loss of time spent in training replacements is always expensive, not to mention the interrupted service to the patients. Furthermore, most of the friction and inefficiency that interfere with smooth operation in any institution may be traced to the misfits among the personnel who probably should never have been employed.

The personnel record makes it possible to effect transfers, promotions and dismissals on an impartial basis, thereby winning the confidence and strengthening the morale of the employed group, which is quick to resent any demonstration of special favoritism or of personal ill will. The knowledge that such a record is kept stimulates healthy competition among the well-adjusted employees, and even the most militant "misfit" must understand the justice of ultimate dismissal when a series of recorded instances of his maladjustment is objectively discussed with him.

In this institution employing more than 1300 persons the personnel work is being carried on by only two staff members, a director and a secretary, who have other duties as well.

EDWARD F. STEVENS

Stevens, Curtin and Mason  
Architects, Boston

# This Hospital to Be



Above: The entrance lobby of the new building, showing the special modernistic lighting fixtures and the colorful terrazzo floor. Right: The Hildreth Memorial library for medical staff members.



AFTER waiting many years for a much needed enlargement and development of the Worcester City Hospital, Worcester, Mass., the city was able to take advantage of a P.W.A. grant.

A careful study was made to ensure the best development of the entire institution for all time and it was finally concluded that some of the old buildings should be removed and a new central unit of multistory structure should be built. It was decided that the original hospital, which was being used as the administration section, and one of the one story wards should be razed and that on this site a new six story modern building should be erected that would form the first unit of a new City Hospital group.

Better facilities were needed for the administration, x-ray, maternity, medical and surgical departments, as well as additional bed capacity.

The kitchen and laboratories were well taken care of in the old buildings and the out-patient department was housed in a separate building a

# e Continued

few hundred feet distant but connected with the hospital by tunnels.

Taking advantage of the natural grade, the main entrance was made on what was the ground floor of the old hospital, extending up through two stories and giving dignity to the approach to the hospital.

The offices of the staff and clerical force, as well as those of the director, the assistant director and the department heads, are located on this floor. The staff office occupies the front of the new pavilion and adjoins the trustees' room and library. The x-ray department is also on this floor and there is connection with the service department, the emergency room and old wards, "K" and "M," which are located in the old buildings.

The x-ray department consists of 11 rooms, including those for cystoscopy, dentistry, x-ray and deep therapy, all of which are furnished with the most up-to-date equipment.

The records room is connected by means of a staircase with the records storage room on the floor below.

The maternity department is located on the third and fourth floors and consists of single rooms, two bed wards and three and four bed cubicle wards. The cubicle wards have partitions between each two beds, affording maximum privacy to all patients. All rooms and wards are connected directly with toilets and all corridor bedpan service is avoided. Large nurseries and washrooms are provided on both floors.

The entire fifth floor is devoted to surgical operating and obstetrical delivery rooms with the necessary utilities. There are six main operating rooms, a fracture operating room and an obstetrical operating room. In the obstetrical section are three delivery rooms besides the obstetrical operating room. Observation galleries are provided for two of the major operating rooms. Three sterilizing rooms are placed between each two pairs of operating rooms.

The wards throughout the hospital are small; none of them contains more than eight beds. These wards are subdivided into cubicled



The new multistoried structure built on the site of the original hospital building. This is the first unit of the new Worcester City Hospital group.

four bed units with a sub-utility room for each eight bed unit. This division simplifies the ward work and keeps the routine work within the ward area. Every patient has his own ventilated locker in the ward. In the single rooms and in the two bed wards a connecting toilet is provided for every patient.

There is a large solarium or waiting room for visitors and patients on each floor. Surgical dressing rooms, routine laboratories, toilets and sink rooms are provided wherever they are needed.

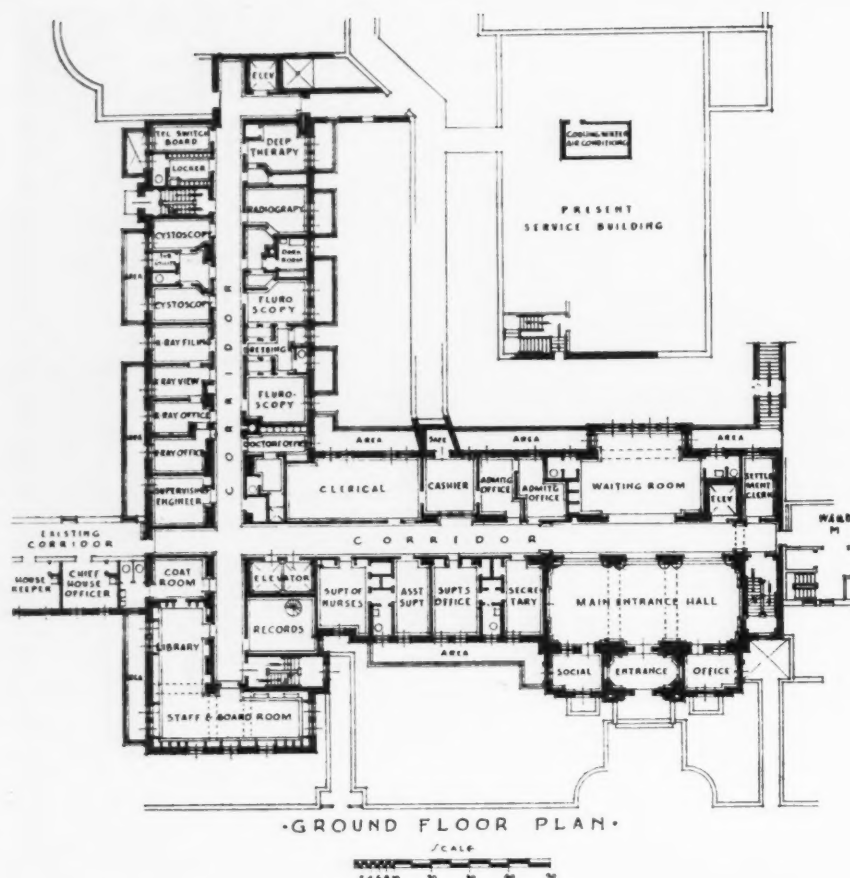
The pharmacy, records storage room, air conditioning plant, telephone switchboard, linen storeroom and locker rooms for the help are located in the basement.

Three high-speed automatic elevators connect all floors and on each floor the food service elevator opens into the serving kitchen.

The physical connection with the old hospital was completed by means of extended corridors on the basement and first floor levels.

Live steam with direct radiation was used for general heating and all operating rooms, nurseries, toilets and closets throughout the building are fan ventilated. The operating rooms, delivery rooms and nurseries are air conditioned. There are heating units in the eight operating rooms and four or five delivery rooms and crèches. These units are so designed that the temperature and humidity of each room can be set at any level that is desired. For instance, when the outside temperature is 105° F. and the humidity reaches 70 or 80 per cent saturation, the room temperature can be maintained at 80° F. or 90° F. and the humidity, at 40 or 50 per cent.

A special conditioning unit was



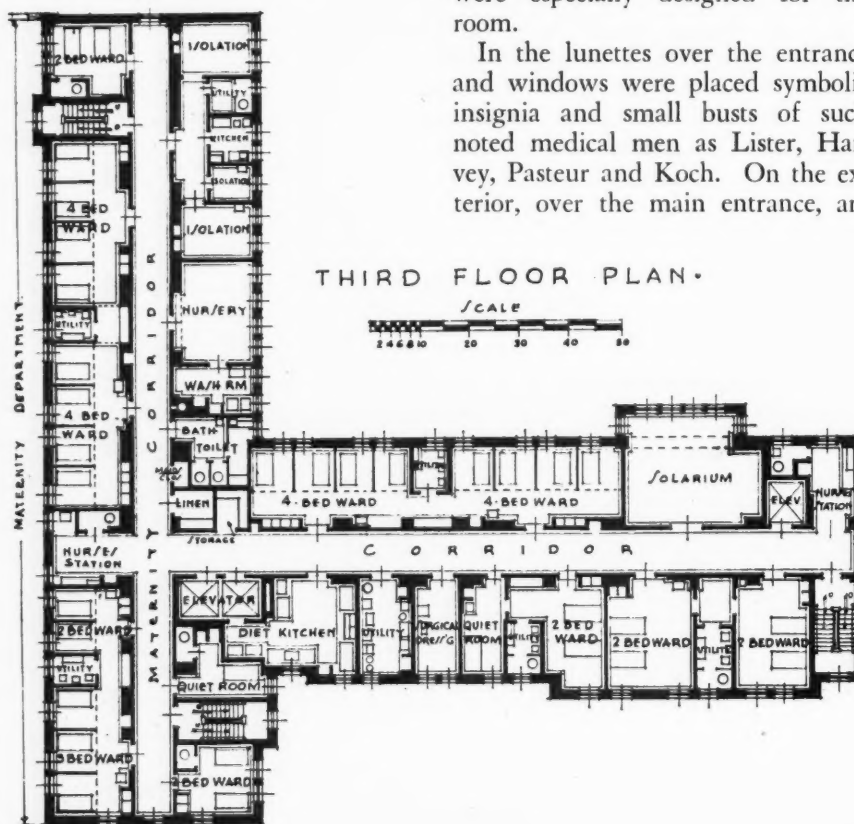
designed that would operate with hot and cold water as the heating and cooling mediums. A coil suitable for both heating and cooling was also provided so that the air can be cooled properly with 45° F. water and heated with 160° F. water. Other requirements were a water spray for humidification; a ventilating wall box fitted with insect screens and dampers; space for a filter element, to be thrown away when fouled by use; a wall panel, and a drain to carry away the condensate.

The cold water supply from brine coils may be supplemented by ice when necessary. This combination of ice and mechanical means for producing cold water is economical inasmuch as it allows the selection of a machine for the normal load and also provides for the use of ice for the peak conditions, which are relatively few.

Alongside the cold water tank a heat exchanger was installed to provide the necessary hot water. This heating is done by steam coils immersed in the hot water tank and automatically regulated to maintain the water temperature as desired.

If the weather should suddenly turn cold, as it often does in New England and the northern states, a

Above: The ground floor plan of the new building designed by Stevens, Curtin and Mason, Boston. Administrative and staff offices are on this floor. Below: Plan of the third floor occupied by maternity department.



weather thermostat placed outside the building makes an electrical contact that automatically shuts off the cold water from the circulating pump and turns on the hot water. It requires less than five minutes to change from the cooling cycle to the heating cycle. The same pump and the same piping are used for circulating both hot and cold water, and motor valves simply operate to supply the pump with hot or cold water. This system allows for one set of piping and one set of radiation, which is less expensive than a double set of pipes.

The cost of the air conditioning system for all of the departments covered was about \$10,000, or \$900 for each operating room.

Steel and concrete frame was used in the construction of the building, with artificial stone trim for the main entrance and basement story and the upper members of the building. The main walls are of red brick. The spandrels between the windows are molded cement, painted to carry the color scheme of the window panels.

The entrance lobby was somewhat elaborated by the use of colorful carefully designed terrazzo flooring. The walls are of stucco with a 4 foot wainscoting of Knoxville marble. Three steps lead to the main floor level. The furnishings of this lobby were especially designed for the room.

In the lunettes over the entrance and windows were placed symbolic insignia and small busts of such noted medical men as Lister, Harvey, Pasteur and Koch. On the exterior, over the main entrance, are

depicted the symbols of Aesculapius and the Tree of Life.

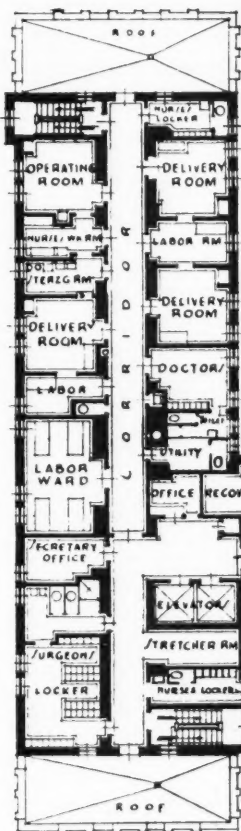
Specially designed plumbing fixtures were used throughout the hospital. These include scrub-up bowls with elbow valves and visible drains; utility sinks with combination spray and plain outlet head; special bedpan washing valves over each of the water closets in the private room toilets; a special locking device for toilet doors between private rooms, and special electrically heated infants' and children's bath slabs.

Special modernistic lighting fixtures were designed for the main lobby and the corridors are lighted by concealed ceiling fixtures. In all patients' rooms a night light is provided in addition to the general illumination. All operating and de-

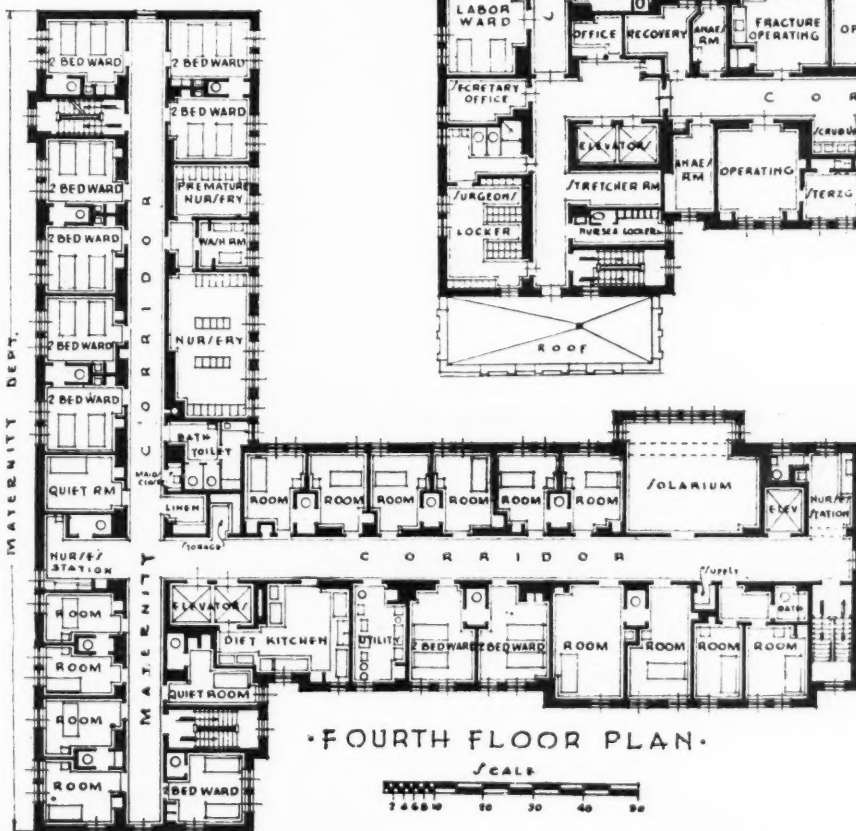
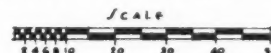
**Right: Corridor on the operating room floor showing a battery of foot-operated scrub-up sinks. The ceiling has been sound-proofed.**



**Right: The entire fifth floor is given over to surgical operating and to obstetrical delivery rooms. The obstetrical section is separated from the surgical operating rooms to avoid cross-infection. Below: The fourth floor is laid out on the same plan as the third. Rooms and wards are connected directly with toilets to eliminate corridor bedpan service. Large washrooms and nurseries were installed on both of these floors.**



FIFTH FLOOR PLAN



FOURTH FLOOR PLAN



livery rooms have special lighting fixtures.

Doctors' calls, in-and-out signals and nurses' calls are all planned to meet modern demands.

The new building as shown on the plans provides for administration and operating departments, a maternity department of 59 beds, 91 beds in general wards and private rooms, a complete x-ray department, a pharmacy and a central linen storage room at a total cost of \$644,000 or \$4300 per bed.

# Let 'Em Take Nines!

THE patient wants service, the doctor wants equipment, the worker wants a raise—and the superintendent wants a headache powder. He is supposed to deal aces all around from a deck that has nothing higher than nines. He is on a spot.

It is the tendency of most superintendents who are on a spot like this to say, "The best I can do is to deal nines, and I will have to try to make nines do." He is constantly explaining why he cannot do this or that. "This is impossible to do," he is always saying, "because . . ." and he goes on to give a perfectly logical explanation of why it is impossible. Sooner or later, if he is a good man, the patient and the doctor and the worker will all be taking nines without beefing.

Occasionally, though, there is a superintendent who will say, "So they want aces? All right, I will deal aces. Only first I will have to get a deck that has aces in it."

There is only one place where a superintendent can get a deck with plenty of aces, and that is from the public. The public has all the cards but it is not easy to get them away from the public. The president of the university wants good cards and so does the community chest. The government is asking for aces all the time and the public always figures that a few cards should be kept under the table in case of a tie. The hospital superintendent who is going to get cards from the public needs help.

## Trustees Hold the Cards

The place for him to get his help is from his board of trustees. His trustees probably will be holding some pretty good cards themselves and they will know where there are lots of others. The big problem is to get the trustees to see the necessity for dealing aces. The average trustee may be inclined to say, "Let 'em take nines," and reach for the financial page to get the close on Consolidated

The author is public relations officer at the Evanston Hospital, Evanston, Ill.

Cogwheels. This is not because he is naturally a hard case. It is because his interest has never been properly engaged. He has accepted a place on the board and attended meetings; he may even have served regularly on one of the committees. Still, he has no real idea of what is involved. He has never been brought to a boil.

He has the right kind of stuff or he would not be on the board to begin with, but he has been let down. He expected to come to grips with the problem, to get inside and see what goes on. And the most exciting thing he has done in five years has been to help the buildings and grounds committee decide to buy a new lawn mower. A superintendent in search of aces will have to go to work on this fellow.

## Shed Inferiority Complex

The superintendent will first have to whip his own timidity. If he thinks his board member is too busy to bother, he is licked before he starts. In all likelihood the board member is no busier than the superintendent; he may handle more dollars, but that does not mean that he is more important. As a matter of fact, an administrator who is not convinced that his own job is just as important as that of any of the board members should start reading the want ads.

Given an honest conviction of his own importance and the trustee's approachability, most superintendents will still fumble the ball. They will go Christian and make an appeal to the man's better nature. They will forget the simple and obvious fact that the board member still wants to get inside and see what goes on. There is no better way in the world to nail him than just to take him inside and show him what goes on.

This is not intended to mean a perfunctory visit to the hospital, or even a series of perfunctory visits.

ROBERT CUNNINGHAM

"This-is-the-operating-room-this-is-the-nursery-this-is-the-children's-ward-nice-to-have-see-n-you-come-again" is no good. Give him that kind of a lecture and his interest will go out like a paper match in a wind-storm. He does not want a conducted tour, he wants to *look* and *listen* and *feel*. He wants to *know* so that he can take his knowledge and experience downtown and talk about them like a small boy who has just been to the circus. When he is shown the clinic, for example, he should be plunked down in a chair in one of the examining rooms, where he can watch the doctors handle a few cases. If his presence is inconvenient or embarrassing to the patient he should not be asked to leave, he should be given a doctor's gown and told to look wise and keep quiet. So much the better.

The same holds true in the operating room and in the nursery, as well as in every other department. It may break a rule or violate an ethic, but the trustee is responsible to the public for the operation of the hospital, and any rule or ethic that keeps him from having a proper understanding of how the hospital operates is a poor one and ought to be abolished. A Sunday morning round with one of the interns will give him more hospital in an hour than he would get in a lifetime of buildings and grounds meetings. Committee meetings are too much like his own business, whatever it is, and what he wants is what the hospital can give him that his own business cannot—what a city editor would call "sock."

## Painless Extraction

A superintendent who is on his toes will find plenty of opportunity during these maneuvers to slip in the needle. A trustee can read or hear about congestion in one of the departments for years and remain as unmoved as a well-anchored Alp. But if he sees patients backing up in

# CARRYING TESTING TO THE RIDICULOUS?

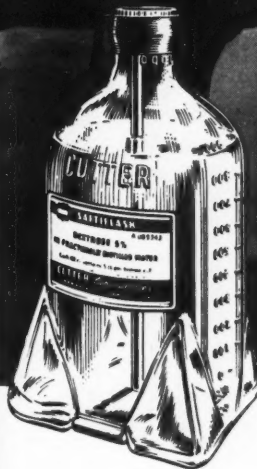
Routine polariscopic examination of solution to determine dextrose percentage

WHAT? Test a simple dextrose solution for percentage error? No good technician would ever go wrong on an "A-B-C" like that!

One of Cutter's, with years of experience, did. He made up a ten percent dextrose solution instead of a five, which the polariscope caught. Yet no better trained or more experienced workers can be found in any institution than in this government-licensed biological laboratory.

The moral is that there is no technician living who is error-proof; no equipment in existence that is perfect. No preparation for injection, regardless how simple, is safe or "as labeled" until human frailty and equipment failure have been ruled out by routine, all embracing, meticulous tests.

Human life is too precious to gamble on an untested solution. It will cost your patients no more to assure yourself of the safety of the solution by insisting on "in Saftiflasks." Nor will it cost the hospital more, for when all costs involved are evaluated, even if testing costs are not included, these solutions prepared in large volume are no more expensive than those prepared in the hospital. Cutter Laboratories, Berkeley, California and 111 N. Canal Street, Chicago. (U. S. Gov't License No. 8.)



ACCEPTED  
AMERICAN  
MEDICAL  
ASSN.

Convenient new  
bail now on  
every Saftiflask

## CUTTER *Saftiflasks*

each other's laps waiting for x-ray treatments he is going to get excited. He will want to do something about it, and a nicely timed remark to the effect that some member of the community might want to donate new equipment may touch him off.

It is a good bet that nothing will touch him off on his first visit, or his second, or maybe his tenth. If he turns a deaf ear to the nicely timed

remark, or if he balks and protests that he will never beg or solicit gifts for the hospital, he should not be given up as a bad job. Because he *will* solicit gifts when his interest is sufficiently engaged. Get him boiling hard and he will boil over.

One by one, up your list and down mine, there isn't a hospital trustee in the country who cannot be made over into a go-getter whose activities

are sure to bring needed support. It takes a lot of effort to make one over and they all have to be made over before the effort will really begin to pay. It takes a lot of letter-writing, a lot of telephoning and a lot of talking. It takes a lot of planning. It's a nuisance. Most superintendents are too busy with their hospitals to bother with their boards. They would rather deal nines.

## Cost Accounting Gets Results

SIDNEY G. DAVIDSON

A SIMPLE cost accounting system that produces all of the essential information required to determine the costs of service rendered in each department of the institution has recently been installed at Grace Hospital, New Haven, Conn.

For a number of years the hospital has followed the general outline of accounting approved by the American Hospital Association. However, with the change in economic conditions that has so directly curtailed contributions it has been forcibly brought to the attention of the hospital administration that adequate compensation must be had for services rendered, especially for the service rendered to the various divisions of the government: towns, counties, cities and states—as well as from insurance companies.

While sound business administration would have seemed to demand that we know these exact costs years ago, it is imperative that we do so now that we have to discuss increased rates with these organizations. As a consequence, the hospital auditors were called into consultation and it was agreed that a complete cost system should be developed.

Early in July 1938 a man was assigned to the work. He began by making a careful analysis of the distribution of such items as heat, light, power and water to all of the hospital departments. In like manner he

Mr. Davidson is administrator of the Grace Hospital, New Haven, Conn.

distributed other overhead costs, such as administration, until every department was allocated its proper share of operating expenses. Following that, all nonearning department costs were allocated to the earning departments. For instance, the operating room, as an earning department, bears its proper costs of general administration, housekeeping, light, heat, power, laundry and nursing; the cost of nursing includes housing, feeding, laundry work and maintenance of dormitories.

Since these figures have been accurately allocated, there will be no need to change them unless some new operation is undertaken in the hospital administration that would affect the cost.

With the cost of each service and the number of services rendered by each department accurately determined, we are now able to obtain the average cost of each service rendered by each department, and from this figure we are able to determine the cost of the care of ward patients. For instance, by taking into account the number of operations performed on ward patients and the average cost per operation, plus the costs of all other services the ward patient receives and regular per diem cost of the room, board and nursing care, we are able to determine the exact cost of the care rendered to every ward patient. The cost of caring for private patients, for children and new-born babies in the nursery is obtained in the same manner.

The hospital now finds itself in the position of having a report each month that shows exact costs and is able to discuss rates based on costs, including depreciation, with any agency with which it does business; one can well realize that this is of inestimable value in obtaining funds for the institution.

In order to carry on this work, the only change necessary in the accounting office was the replacement of one clerk by a competent bookkeeper who was familiar with cost accounting, which meant an increase in salary expense of \$30 per month.

As previously pointed out the falling off of contributions and investment income has made more acute than ever before the need for definite cost statistics in the administration of hospital affairs. Like any other type of business, a hospital must be assured of an adequate return for the service it renders in order to continue as a going concern. Moreover, a hospital is in the position of having to maintain a high standard of effectiveness in the best interests of the community it serves. In order to maintain its standard, it is vital to the hospital to know the cost of its service and what it will be obliged to charge therefor in order to ensure satisfactory results to all patients as well as successful administration of the institution.

Grace Hospital feels that it is now more adequately equipped to plead its cause in the matter of hospital costs and urges the serious consideration of such studies by other institutions for the care of the sick.

## Building Our Buttress

WHEN the sole purpose of a building was to provide shelter over a man's head or protection from prowling animals, architectural forms were simple and almost any materials would serve. As society became organized and structures, notably churches, were reared for social purposes, architects were presented with new problems to meet their constantly growing size and height. Stone being the only material then available, means had to be found to offset the outward thrust of the vaulted ceilings which, unless counteracted, would have pushed the walls outward and collapsed.

To permit larger and finer cathedrals to be built it was necessary to develop buttresses, the function of which was to provide weight outside the building to hold it together. These took many forms but achieved their most spectacular development in the so-called flying buttress, one of the crowning glories of Gothic architecture.

From the earliest days of man injuries, illness and death were ever to be feared and they, too, were met simply and by anybody within reach of the afflicted; sympathy and proximity being the only qualifications necessary or possible.

### Hospitals Become Complex

The "cathedrals of the healing arts" in which medical science has flowered so bounteously in the last fifty years are no longer simple structures merely for shelter or protection. Some authorities claim that in a complete general hospital not more than 30 per cent of the space can be allotted to patients' beds without crowding the many special facilities needed for their proper care.

Within the hospital simplicity has given way to complexity as the steady advance of science has revealed new and better ways to meet old needs. Functions have been specialized and simple duties have been

developed into professions. The kind heart and helping hand now work through the scientific mind and through skilled technics, each functioning in its proper place to make the modern hospital an institution in which yesterday's miracles, wrought only by prayer, are today's routine accomplishments, flowing safely and surely from the combination of skills and facilities now at our command.

But these benefits can be had only at a price that somebody must pay. There being more "somebodies" who cannot pay than who can, it falls upon society to provide the growing margin between financial intake and outgo to keep the machinery efficient and properly served.

From early days such institutions have commanded the services of men and women actuated by good will and the desire to serve their fellow man through organized charity in various forms. When no special skill was available inside the hospital not much was required of its lay boards. Today, when even the profession of medicine is divided into special fields, it is only the exceptional trustee who can acquire even a casual knowledge of hospital administration.

The captain who can take his ship safely around the world with compass, sextant and chart could not make or perhaps even repair the chronometer or other delicate aids to navigation upon which he must depend, though in a careless or unguarded moment he might injure or even destroy these vital instruments.

Our lay groups, then, may be likened to the agents or directors of the steamship line. They raise the capital, obtain the cargo, see to the insurance, determine the destination and fix the rates; but once the ship puts to sea it must be in professional and skilled hands capable of directing and coordinating all its many and delicate parts.

Someone has put this well in an

article entitled "The Executive at Sea," in which the hospital administrator is compared with the captain of a ship, but with this significant difference: "The obligation to steer a straight course is there for both, but there is no 'back seat' driving at sea. . . . One haunting thought follows the hospital administrator when he sets foot on land and that is the ability of the captain to isolate himself on the bridge and surround himself, undisturbed, with men of technical ability when he has a problem to solve that concerns the safety of those who are entrusted to his care for the voyage. There are lessons to be learned everywhere, but one must be on the high seas to experience the thrill of knowing, by the best proof, the value of sound and efficient executive service."

### Sound Judgment Required

We grant freely the ability of many devoted board members in their respective fields and welcome the contributions that they can make to technical problems arising in our work. If these outstanding men and women could treat our problems as they do their own, our work would go forward by leaps and bounds. However, the contributions that these people make to us are rarely from fresh minds, but in hurried meetings, on the way to the office, on the way home to dinner or in an evening snatched from other activities. The professional consultant, whether he is an architect, lawyer, banker or engineer, sees his problems in operation, collects his data, plots his charts and consults his authorities, in order to arrive at sound conclusions, even though the subject is one upon which he has concentrated for many years. Granting that the problems of hospital administrators are quite as complicated and that they lie generally outside the fields of exact science, can we expect to obtain truly sound judgment by lay people in these brief contacts when quick decisions must be made?

Just as science has widened the

horizon of medicine within the hospital and hence has increased in number and perplexity the technical details of management, so has society broadened its field of work and the problems outside its walls. Our supplies come now from all parts of the world, making customs, tariffs and foreign wars matters of grave concern. Motor car accidents bring us patients from distant points, often without funds. Legislation intended to affect industry is placing new costs on the hospital's back. Nation-wide channels of publicity may proclaim an unfortunate incident in one hospital for the whole world to hear. Economic conditions progressively undermine sources of charitable gifts, requiring greater efforts in solicitation and in telling the story of the hospital to giver and taxpayer alike. Relief problems bear hardest of all

on the hospitals since they cannot decline the patients, no matter what their means may be.

Responding to the challenge, medicine, nursing, dietetics, social service, housekeeping and, finally, administration itself have developed their fields with specialized professional training. Yet none of them is qualified to cope with those other problems of community relations. This field, then, is ripe for the trustees and unless it is cultivated by them promptly and vigorously all the good work inside the hospital may fail from internal pressure and inadequate support. Just as the cathedral would have been impossible without the buttress so the modern hospital will fall without the outside support that only trustees can give.

No longer should it be necessary for the board member to check up

on personnel if he has done his part to obtain for the hospital capable and conscientious workers in all departments. It is his duty to see that everything necessary and possible has been done to surround the patient with facilities and staff adequate for his needs and to use his influence at all times to keep them so.

No board of men and women imbued with a true conception of a hospital will ever lack for tasks that they and they only can perform. The solid citizen in his daily contacts can build up the structure of the hospital in its community. The active club woman can spread its message to large groups and obtain material support and the personal services of volunteers. The professional and technical expert can grapple with its problems in engineering, finance, law, legislation or publicity. These may correspond to the "engaged columns" or other forms of buttress that give strength to the structure.

As for that peripatetic business man who today may be in New York and tomorrow in Chicago, San Francisco or points between, can he not, by taking with him the message of the hospital as an institution, give distinction to our edifices as do the "flying buttresses" of our imperishable cathedrals?

The world at large is suffering from lack of understanding and cooperation. Our hospitals need and deserve both of these qualities in great measure. Trustees can provide those essentials and make our work not only more successful but infinitely more satisfying. Few know how necessary and urgent is the help that board members can give, or the joy they will find in providing these forms of external support.

The dangers that face us are not inside, but outside, where our hands cannot reach. Fewer gifts, interrupted appropriations, higher tariffs, wage and hour laws, labor troubles, reduced incomes of patients and government intervention are all threats to our voluntary hospital system.

We might well consider the urgent message written under similar conditions by General Lafayette to Governor Lee of Virginia in July of 1781, which concluded with these words: "Languor in our public exertions for this campaign may not perhaps be balanced by the most strenuous in future."

## WHAT THEY ARE SAYING

### Happy Family

• As the employer of some 300 hospital workers, we have never yet thought of them—as some employers do—as a happy family. We think of them and, we hope, treat them as three hundred and some separate individuals working at many widely different tasks to bring about the same result, proper care of the sick.

When cooperation between these individuals is necessary to the job we expect and get cooperation, not because we are a happy family but because it is necessary to the individual's own accomplishment. It seems to us rather dangerous for an employer to let his results depend to any extent on whether Joe likes Bill, or whether both of them feel just that way about Harry. If Joe and Bill and Harry have a job to do together, let each one understand what he must bring to it to get it done. As a matter of fact, a little competitive jealousy—call it ambition, if you want to preserve the family atmosphere—will help to get the job accomplished more than it will hurt.

All this is not to say that we are not interested in employe welfare. On the contrary, the exacting tasks involved in caring for the sick require a finer adjustment than almost any we think of. We believe in adequate wages for all classes of workers. Because our location makes it difficult for employes to find living accommodations near by, we provide a residence for those who wish to avail themselves of it. Nothing

is left undone to bring every employe to the point at which his best abilities can be brought to bear on the work he has to do.

Naturally, a major concern is for our employes' health. Hospital and medical care is provided as needed for those who are sick; a recent policy makes periodic physical examinations compulsory for all employes.

The first round of examinations, 347 of them, has just been completed; 347 hearts have been carefully listened to, 347 "pedigrees" taken, 347 blood tests made and reported from the laboratory, 694 lungs examined and x-rays without number taken and studied when the faintest suspicion of a defect existed.

Residents, interns, nurses, technicians, office workers, engineers, porter and maids—all hospital workers—have taken their turn in the examining rooms, with staff doctors doing the examining. As a result of these tests all are in the tiptop condition that is required for superlative performance on the job, and nothing less than superlative performance will do.

Sounds like happy family stuff. If it is, it is a by-product. All we are trying to do is to build up the kind of organization that will give our patients the best hospital care they can get. If we have created a happy family in the process, it probably won't do any actual harm, but we would still rather think of them as 300 individuals at work.—THE PILOT, *Evanston Hospital, Evanston, Ill.*

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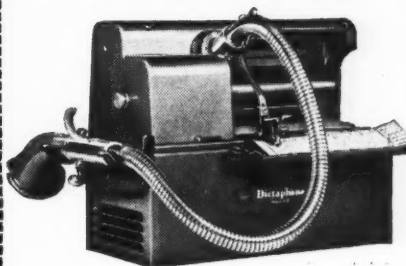
. . . Any reports on a patient's progress must be recorded promptly and accurately. Otherwise the record is insufficient for the physician, surgeon, interne and nurses assigned to the case.

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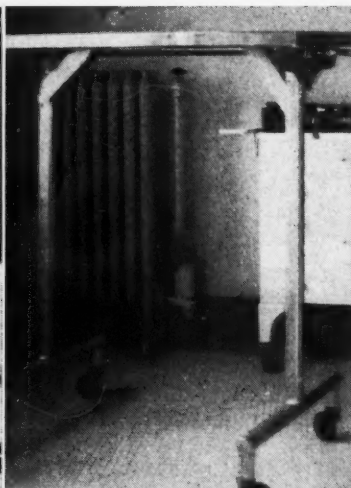
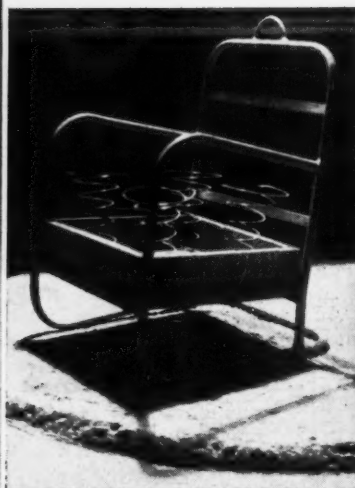
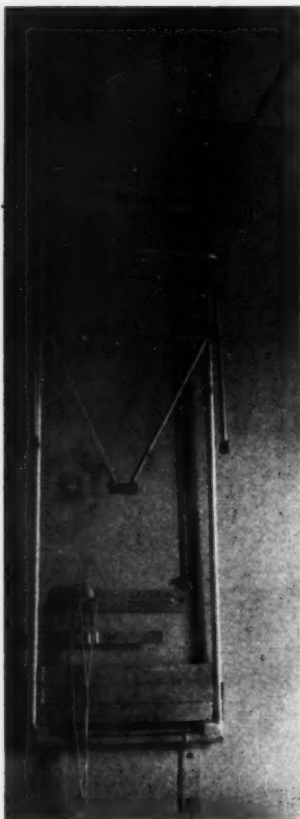
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## Repairs Well Done by Welding

MARION PARK



Some of the equipment wrought in the shop of St. John's Hospital, St. Louis. From left to right: A fracture bed, a child's chair, an instrument table and a boiler room ladder.

SEVERAL years ago we purchased an oxy-acetylene welding outfit at St. John's Hospital, St. Louis, and since that time we have used the equipment to do practically all of our own metal repairing, much of which was formerly sent out. In addition to that, we have fabricated many useful pieces of furniture around the hospital and have mended many parts that would otherwise have been thrown away.

An important advantage of the outfit is the fact that material that would ordinarily be discarded as scrap can be used in some form or other. For instance, we have recently made three silverware cabinets, the frames of which were completely welded from scrap pipe and then covered with wood. The ultimate cost was less than buying a new

Mr. Park is chief engineer at St. John's Hospital, St. Louis.

cabinet and the construction was sturdier.

For the kitchen we made a handle assembly for a platform truck; the handle was made from scrap pipe and then welded to a steel plate attached to the wooden platform. This platform truck is used to haul heavy materials from the kitchen to various parts of the hospital.

A grinder stand made from 1 inch used pipe is used in our machine shop and is mounted on casters so that it can be moved from place to place.

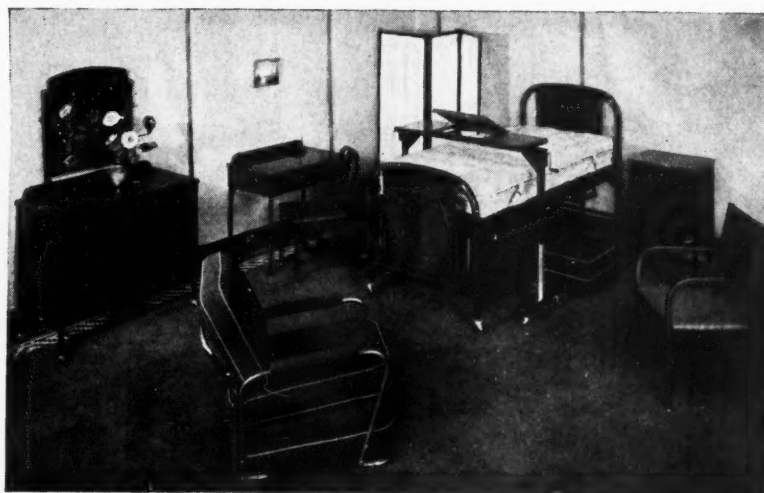
Other equipment made from used pipe includes the following: 12 three-legged wash stands of  $\frac{3}{8}$  inch pipe which replaced some old ones made from riveted strap iron that were shaky and noisy; a strong all-welded work bench for use in the maintenance shop to take the place of an old wooden bench that had rotted

away, and six carts mounted on rubber caster wheels that are used to haul ice water on the various floors. These carts are 34 inches high, 18 inches wide and 26 inches long, made with five legs. Two of the back legs serve as gliders and clear the floor by about half an inch. This arrangement reduces the noise and helps the steering.

Of particular interest are the three trucks that were made for transporting oxygen cylinders for medical purposes. The framework is made of  $1\frac{1}{2}$  inch by  $1\frac{1}{2}$  inch angle iron. The rear corners of the truck are raised about half an inch off the floor and serve as gliders to prevent the truck from tipping over. One of the features of the truck is a  $\frac{3}{8}$  inch rod bent in a semicircle that is used to hold the cylinder in position. Covering this rod is a rubber hose instead of the conventional chain be-

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Now it is possible in addition to the full protective advantages of Inland Portable Bed Sides to have the added convenience of a crib-type sliding construction, which permits immediate access to the bed or patient. The side drops parallel with the bed, eliminating interference with bedside tables or other furniture. The sliding drop-side construction is operated by a hand trip, out of reach of patient. The side is removed only when you wish to transfer it to another bed. Fits any standard hospital bed.

### A CHALLENGE TO PAST ACHIEVEMENT

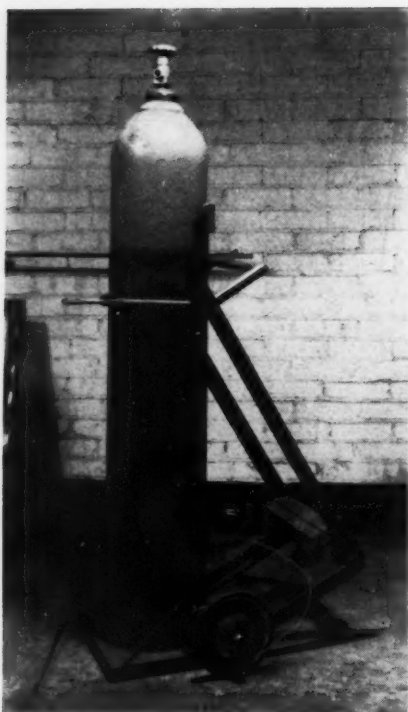
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**Portable oxygen cylinder truck.**

cause the rod covered with the hose is noiseless.

Six benzoin inhalers were fabricated from pipe angle iron and strap iron. The framework of each consists of  $\frac{3}{8}$  inch tubing and small angle iron for cross braces. An empty five gallon vegetable oil can is set in place in the angle iron supports and this serves as a jacket for holding insulating material. Inside the can is the heating container made from a piece of pipe 8 inches in diameter and closed at both ends by two plates that are welded in place. In the bottom plate a hole was made and threaded to accommodate the electrical heating unit. On the top of this can there is a dome-like vessel made from a half copper float, bronze-welded to an 8 inch tin pie plate; a  $1\frac{1}{4}$  inch flexible tubing was bronze-welded to the float. The completed dome-like vessel was then chromium-plated while the exterior of the framework was painted. The inhalers, because of their welded construction, are extremely rigid and noiseless. An important advantage is the fact that they hold twice as much liquid as did the type that was used formerly.

Frequently our doctors require fracture splints of different types, weights and sizes, which makes it hard to carry the exact kind in stock.

However, by welding, it is possible to shape any sized splint the doctor may want and we use various thicknesses of brass rod for this work.

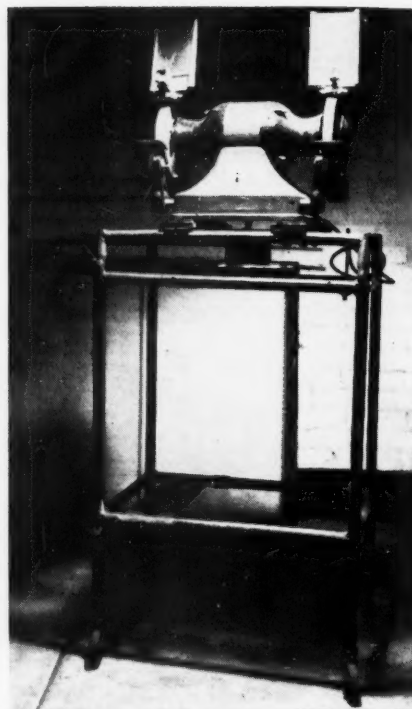
Tubular chairs were made of used pipe for the nursery. The principal feature of these chairs is the small hand-hold on the back to facilitate easy moving. A fracture bed that is completely welded of pipe was constructed for use in the operating room. It is attached to the wall and ceiling and is so placed that it can be dropped when needed and folded back against the wall again when not in use.

An instrument table was designed and made specifically for use in brain operations. This table is fitted with an acme screw so that it can be lowered and raised and is used to hold the instruments during brain operations. The table is higher and wider than the operating table so that it can be rolled over it. The top is of stainless metal and the framework is of  $1\frac{1}{2}$  inch pipe and  $1\frac{1}{2}$  inch square tubing that were subsequently chromium plated.

The flexibility of a welding and cutting unit is of value in constructing other types of equipment. An example of this is an ice chute that was made entirely of metal by the use of the welding outfit. The purpose of the chute was to convey ice blocks from the ice house to the ice dump, a distance of 20 feet. The framework of the chute was made from 3 inch angle iron heated by the torch and bent in a semicircle to conform with the space available



**Framework for benzoin inhaler.**



**Grinder stand mounted on casters.**

in the building. Galvanized sheets were welded and attached to the angle iron and the entire structure was supported by several legs made from  $1\frac{1}{2}$  inch pipe. This chute has proved to be highly satisfactory.

We also manufactured ladders for use in the boiler room. The ladders are 12 feet high and 18 inches wide and are made from 2 inch angle iron. One inch scrap galvanized pipe was used as a railing and the ladders were set in concrete for permanency.

A good deal of money has been saved by the use of this equipment for maintenance. Among the repair jobs for which the welding outfit was used was a small gear from one of the laundry machines that had had a tooth broken out. A bronze weld was made and the tooth was put in by the use of bronze welding. Recently a leak developed in a 12 inch steam line near the cast iron flange. This leak was promptly and effectively repaired by bronze welding.

Some of the other maintenance work done included five cast iron grate bars repaired at a saving of about \$12 each and a yoke for an ironer in the laundry. Contacts in circuit breakers from a passenger elevator were built up with bronze welding at a considerable saving in money and time.

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There *are* men and women like that. There are men and women like those who've hitched their wagons to the stars,

there are men and women ready, waiting, to bring to you those things you need and want: the *fame* that comes from great good done; and *faiths* and *beliefs*; things that stay in hearts and minds for years.

If you will write and tell us the type of man or woman that you want, tell us of their duties, tell us of the lives they would have to live, tell us how they'd fare if all goes well . . . . .

. . . . . it might be that we could select the people that you want and send credentials on to you tomorrow, for already we have a *priceless* group, *your* kind, *our* kind of men and women for the finer hospital tasks you have . . . . .

. . . . . or, we will find them for you; that is our great work.

## The MEDICAL BUREAU

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# Small Laundry Saves Money

MABEL WILKE

WHEN the Ripon Municipal Hospital, Ripon, Wis., was being planned it was decided that it must be up to date in every respect. Those who were charged with the responsibility of building the hospital and the commissioners who were to equip and operate it visited many small hospitals in order to familiarize themselves with all phases of hospital building and equipment. During these visits it was noticed that some hospitals operated their own laundries while others depended upon commercial organizations. Special attention was, therefore, given to that department and the architect's advice sought. He stated that it was not considered practical to operate a laundry in a 20 bed institution. Yet the experience of other hospitals indicated the advisability of providing for this department. Further investigations and discussion with laundry engineers convinced the hospital commission that a laundry could be made to operate economically and efficiently in this small hospital if proper equipment was selected.

## Laundry Can Be Enlarged

The building plan did not allow for much space for the laundry room. However, approximately 225 square feet was allocated to this department and the room was fitted with the necessary equipment. The commission felt that eventually the hospital would need to be enlarged so the laundry was planned to take care of approximately twice the initial capacity. The equipment consists of a washer, an extractor, a tumbler and an ironer. The washer, which has a capacity of 40 pounds per load, is built of wood, equipped with a belted motor drive and has a water glass and thermometer to provide accurate control of formulas. All the washing, rinsing and bluing are carried on in this machine.

Miss Wilke is superintendent of the Ripon Municipal Hospital, Ripon, Wis.

A 20 inch extractor of the heavy duty type is used for the wringing. It is equipped with the proper interlocking devices, driven by a 1½ h.p. motor.

A small open-end drying tumbler was chosen. This machine shakes out the work after extraction and eliminates hand shaking. It predries to the proper point work that is to be ironed and fully dries work that requires no ironing. This little tumbler aids in reducing labor and time and also helps to produce a higher quality of laundering.

The ironer selected is a large domestic size with a roll 7 inches in diameter and 48 inches long. It is automatic in operation, an excellent feature, since it permits much of the wearing apparel to be partially ironed. Uniforms are usually ironed on the automatic machine and then finished with little effort on the hand ironing board. For hand ironing a regular laundry type of ironing board with attached sleeve boards and other features to provide most convenience for the operators was selected.

All of this equipment cost approximately \$1500.

Installation of a high pressure steam plant was found to be entirely too costly so the sterilizers chosen were of the electrically heated type. The laundry equipment is operated by gas heat because it does not need the automatic regulation required in sterilizers. The gas heat has proved both economical and efficient.

Bed occupancy at Ripon Hospital has been well over the average for hospitals of this size; consequently, more linens have been required and the saving effected by the operation of the laundry has been larger than normal. Checking is done from time to time to determine the amount of work passing through the laundry. It is then priced on the basis of commercial laundry rates and compared to the cost of operating the hospital laundry. The following is an aver-

age set of figures, covering the handling of more than 3000 pounds of work per month.

Commercial Laundry Costs: \$202.45

Hospital Laundry Costs:

Washing Materials \$ 8.00

Electric Power

(240 kw.) 4.80

Water 12.00

Gas (12,000 cu. ft.) 18.00

Help 65.00

Depreciation 13.35

Total 121.15

Saving \$ 81.30

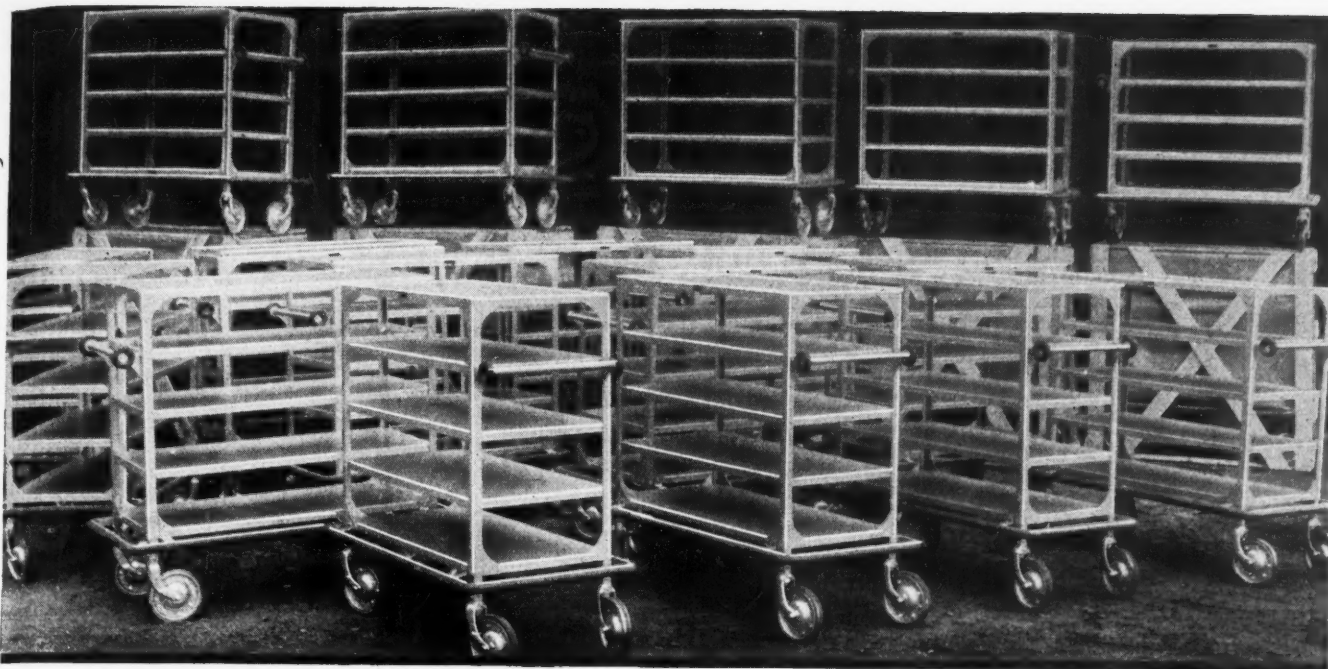
The cost per pound is 2.7 cents.

Most of the time one employe is able to do all of the work satisfactorily. Sometimes it becomes necessary to provide extra help for perhaps an hour or two in the busiest periods. We first employed a woman who had had experience in a commercial laundry but she could not stay and other arrangements had to be made. Unfortunately, the first operator left suddenly but the janitor had been instructed in all of the processes and formulas and he promptly stepped in and operated the laundry for several days until a new employe could be hired. This woman has been handling the work for two years and is doing an excellent job.

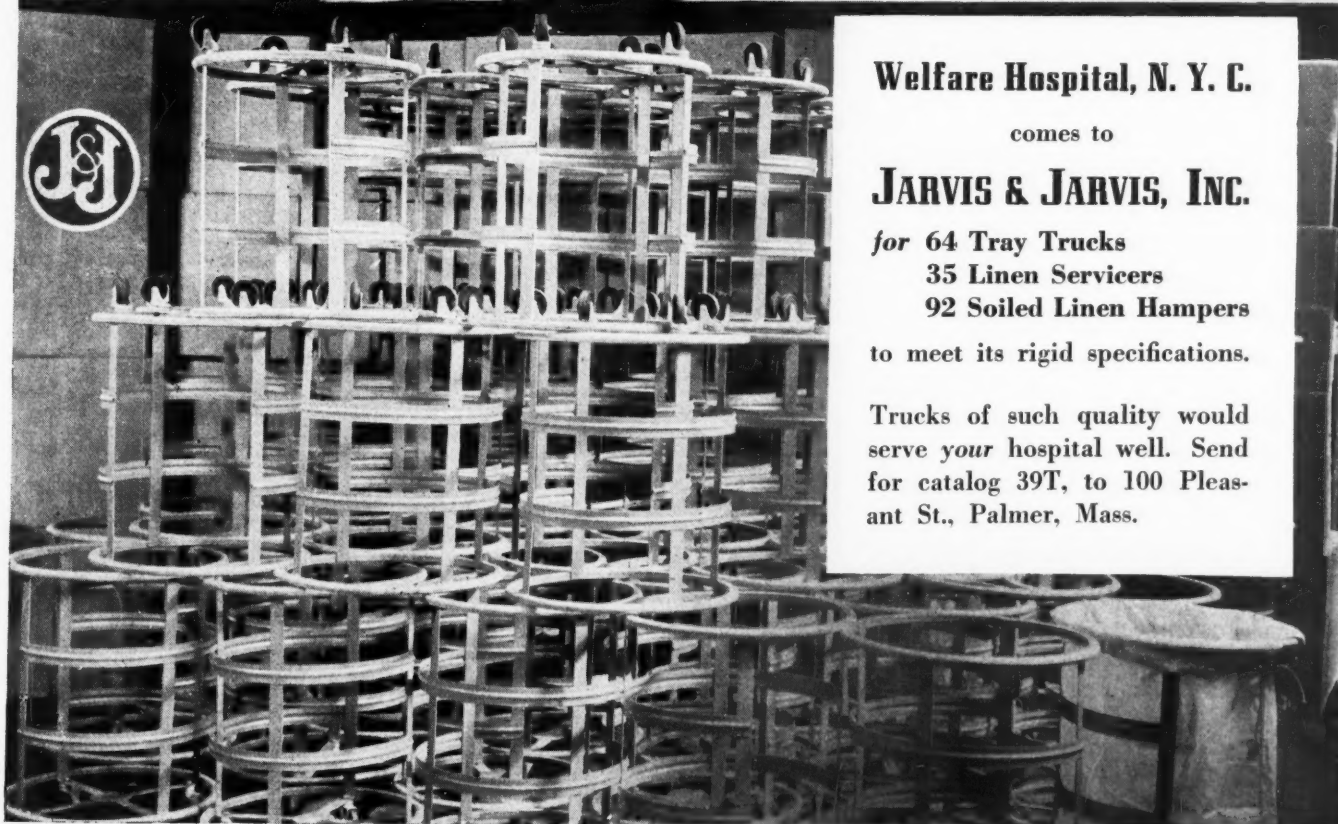
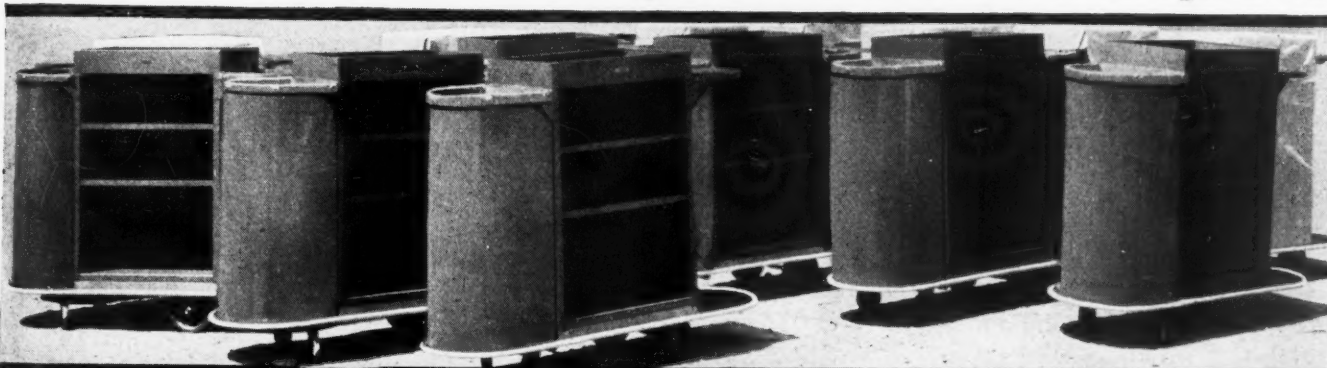
## Initial Cost Saved

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## Problem in the Pantry

MILDRED L. BURT

ON each floor of the Mountain-side Hospital, Montclair, N. J., there is a small kitchen from which the food sent up by the diet kitchen is dispensed. These kitchens are equipped with refrigerators, gas stoves, toasters and small cooking equipment for the use of the nurses in accessory food service, as well as with sterilizers and sinks for washing the dishes used. A maid on each floor is responsible for washing the dishes, keeping the dish cupboards, refrigerators, gas stoves, silver and tables clean, and for setting up the trays in preparation for serving the food.

In the kitchen on a private floor, considerable difficulty was experienced because of the apparent inability of the maid to cover the work effectively. It was a difficult floor, to be sure, because of the large number of "special" trays for private patients and also because of the presence of a considerable number of nurses preparing trays for patients which resulted in a crowded and confused condition in the kitchen at certain times of the day.

### Maid Submerged by Dishes

However, this kitchen often looked untidy, even after the maid's work was considered done and her refrigerator did not look as scrupulously clean as it should. She, too, usually gave the appearance of being submerged by her work. Apparently it took her so long to do her morning dishes that she had no time left for the "extras," such as cleaning silver, refrigerators and closets, which should have been cared for each morning. Substitutes working in the kitchen during her vacation and "days off" seemed to cover the work

Miss Burt is housekeeping director, Mountain-side Hospital, Montclair, N. J.

better than she and with less effort.

There was a good deal of discussion as to whether the maid should be discharged, put in a smaller kitchen or be permitted to continue as she was doing. It did not seem fair to give her job to one of the other maids simply to make it easier for her and we did not want to let her go because she was in need of the work. Yet we felt that in fairness to that department, we should not shut our eyes to the failure of this kitchen to measure up to standard.

### Time Study Made

The answer to the problem seemed to be a job analysis that would include a time study of this maid's work to note whether there were any short cuts that might be effected. Was this maid using the best methods possible and did she have every opportunity and aid in trying to get results? It was only fair to check carefully before dispensing with her services.

First, a time study was made in an even larger kitchen in which a capable maid seemed to be covering the work effectually and with considerable ease. After accomplishing this and noting her methods, a similar time study was started of the maid under consideration, to determine how she might improve her work or whether too much was expected of her.

This study revealed that she was spending a great deal of useless effort in preparing the dishes for washing. Trays were brought in and placed on a table where she dismantled them and prepared the dishes for washing. A large garbage can and a waste basket were located near the sink, but at a little distance from the table so that, as

she was scraping each dish separately into the can, she took a number of useless and time-consuming steps in transferring the waste food to the garbage cans. She was also making numerous trips in order to pour waste liquids into the can, since, if her sink happened to be filled with dishes waiting to be washed, there seemed to be nothing else to be done with them. It was also discovered that she was not stacking dishes carefully but was washing first a few of one kind, then a few of another, utterly unmindful of whether she was washing glasses first and separately, or washing them with whatever might happen to be in her sink at the time. All this resulted from a gradual letting down in her methods of work, since she had been better trained by another employe when she started to work.

Accordingly she was provided with a smaller pail placed on a box by the table where the trays were dismantled, with a pitcher marked "waste liquids" to receive liquids to be thrown away and with a waste basket for papers. She could then proceed to clean up the soiled trays, empty the waste without moving from her place and empty the various receptacles surrounding her in one trip from the table to the large receptacles.

### Dishwashing Rules Established

Following this she was assigned a definite procedure, phrased in simple personal language, easily comprehended by minds unaccustomed to following written orders:

#### *Getting Ready to Wash Your Dishes:*

1. All trays with soiled dishes should be placed on the tray racks.
2. Put away all food.
3. Place on the table: pan for soiled silver; pan for liquid waste.

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4. Put small garbage pail on stool at left of table.
5. Put waste paper basket at right of table.
6. Stack dishes alike together.
7. When there are too many dishes for the table, place some in the left hand tub and fill with hot water.

#### *Washing the Dishes:*

8. Fill the right hand tub with hot water; add soap.
9. Wash glasses first.
10. Put glasses in the sterilizer.
11. Wash silver.
12. Put silver in the sterilizer.
13. Dry glasses; set up trays; put the rest away.
14. Wash cups and put in sterilizer.
15. Let dishwater out and run in clean water.
16. Dry silver; set up trays; put the rest away.
17. Wash flat dishes; put in sterilizer.
18. Dry cups; set up trays; put the rest away.
19. Dry flat dishes; set up trays; put the rest away.
20. Wash pots and pans first or last.

The maid was provided with a plate scraper for cleaning the dishes and with a sink strainer for draining off the liquids. We also instructed her in the method of stacking dishes and the order of washing.

During this study, she evinced a certain reluctance to accept fully the new ideas. She apparently felt that her own methods were satisfactory and that our suggestions would be of no advantage to her. This made it necessary to explain to her that we were uncertain about retaining her and that it was our wish to help her to cover her work in a satisfactory manner, thus ensuring her position. Thereupon her attitude improved and she adopted the ideas without reservations.

A demonstration was staged in one of the kitchens with two of the most intelligent maids actually doing the work in the approved way before the other maids. As it progressed, reasons for certain procedures and what we hoped to accomplish by these methods were explained. Mimeographed copies of the outline of methods of work were given to each of the maids and we plan to give

one to each new maid as she enters the hospital's employ. Each maid was urged to try it in her own kitchen insofar as differences in structure and setup of the kitchens would allow.

As soon as the plan was put into operation, a decided improvement in the maid's work was noted. Whereas she had previously taken nearly the entire morning for routine

picking up and dish washing, leaving little time for other duties, she now finishes her routine work well before the middle of the morning and has time for "extras" before noon. She seems happier than before because she feels that she has conquered the job. The kitchen, too, is tidier, and we feel that the time required to study this problem and find the answer was well spent.

## THE HOUSEKEEPER'S CORNER

- Ink stains on broadloom and other carpets having a deep nap may be removed with milk if the stain is fresh. One housekeeper sponges such stains with cloths saturated in milk, replacing one cloth with another until all the ink has been removed. Afterwards she washes the spot with lukewarm water in which a good grade of soap has been dissolved and rinses it with clear water.

- There is no confusion regarding the distribution of clean linen to the obstetrical and children's floors in the Milwaukee County Hospital, Milwaukee. Mrs. Isabel Bernhart, the executive housekeeper, has evolved the bright idea of lining the linen trucks with different colors. The hampers for the children's floor are lined with orange and those for the obstetrical floor, with orchid. Soon she plans to use green lined hampers for the general floors.

- The routine equipment that the housekeeper must have can be bought by the purchasing agent, but the materials she has to choose from day to day she must purchase. How should the housekeeper buy? The answer is: from just as few people as possible. She should not, unless it is routine, send out for bids. If she does, she will get exactly what she pays for, and it is not always the thing that costs the least that is the least in cost. There should always be someone in the organization from which she purchases who knows the housekeeper by name and whom she can call upon when she is buying.

There is nothing that is more valuable than the personal touch. In big organizations where purchases are made in carload lots, or even larger quantities, \$400 or \$500 worth of standard goods, for example, it is better

for the purchasing agent to buy them and the housekeeper to store them. Aside from that the housekeeper should buy what she needs herself. She will be better off at the end of the year, and if the figures show red, they won't be as far in the red when the housekeeper does the purchasing.—JOHN D. McLEAN, M.D., *Rush Hospital, Philadelphia.*

- Hospital administrators with a limited budget for the maintenance of furniture and equipment are frequently puzzled about ways and means of keeping antiquated furniture in an up-to-date condition. A limited budget prohibits an entire replacement of equipment at any one time.

Fifteen or twenty years ago posture beds were a luxury and many institutions were fortunate in obtaining beds equipped with head rests only. After years of constant use the springs of such beds are found to have lost much of their resiliency; the head rests need constant repair. In some cases the casters do not fit, causing them to drop from the shanks of the bed whenever the ends are lifted.

This old equipment may be brought up to the minute through the co-operation of bed manufacturers. The latest posture spring can be built to fit the bed ends. The newer type of rubber caster and socket may be fitted to the shanks. The manufacturers will allow a salvage on the old bed springs. The reequipping of old hospital beds adds much to the comfort of patients and saves money for the hospital.—SISTER PATRICIA, O.S.B., *St. Mary's Hospital, Duluth, Minn.*

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## Dietetics in China

HELEN BURKETT DRUMMOND



nurses who are in charge of diet kitchens in other hospitals. The chief of the department acts as consultant for the food service in the medical wards and nurses' and employees' dormitories.

The professional staff consists of one foreigner and five Chinese assistants. One Chinese assistant is a graduate of Johns Hopkins and the others are Yenching University home economics graduates with one year of dietetics training at Peiping Union Medical College. The course offered is based on the requirements of the American Dietetics Association.

The nonprofessional staff consists of: 21 cooks and assistant cooks, 3

**A** MISSION hospital called the Union Medical College was established in China in 1906 and from this beginning developed the present Peiping Union Medical College. In 1915 the China Medical Board of the Rockefeller Foundation assumed full support of the earlier Union Medical College and a year later it was granted a provisional charter, later made permanent, by the University of the State of New York. The present fine buildings of the medical college and hospital were completed in 1921. It is a general hospital of 350 beds of which 14 per cent are designed for private use. The hospital is equipped with medical, surgical, obstetric, gynecologic and eye wards, in addition to a children's division. The isolation unit accommodates 25 patients and is equipped to handle both children and adults.

The dietary service has the following duties: purchasing, preparing

The author is chief of the dietary department, Peiping Union Medical College, China.

**Above:** A section of the main kitchen at the Peiping Union Medical College and Hospital. The cook is preparing a meal on the coal-ball stove. **Right:** First year student dietitians working in the laboratory.



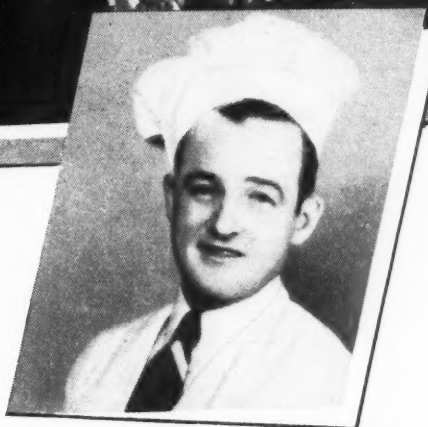
and serving food for the patients and special duty nurses; teaching nutrition and dietetics to nurses and medical students, and offering a one year course for student dietitians and a four months' course for graduate

waiters, 1 milk boy, 2 storeroom boys, 4 food cart boys, 1 coal-ball boy, 7 coolies, 1 pot washer, 1 typist and 1 secretary.

All employees work nine hours a day (exclusive of meal hours and



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YES, SIR AND MA'AM...almost any evening you'll find Chef-Steward George Mize of the famed Atlanta Biltmore is just about the busiest man in the whole state of Georgia!

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"...Catering to such a variety of tastes from one central kitchen requires most careful attention to purchasing such materials as may be used in all menus without having to carry an excessive inventory. Also, it is very necessary to know what percentages your purchases will produce in the completed menu.

"The purchase and preparation of fruits and vegetables constitute a very definite problem. A variety of fine, quick-frozen foods available assures a consistent supply to eliminate the hazards of using seasonable goods. Birds Eye Frosted Foods are the best quality line available...

"Of the number of Birds Eye products offered locally, we use all the varieties suitable for hotel menus... For arranging a complete menu, with every item uniform, attractive, and tasteful at a known, fixed cost, including labor and food cost, it is a revelation to have such an outstanding source of supply."

Birds Eye Foods come all washed, cleaned, ready to cook or serve. You can depend on their fine, uniform quality. And—whether you use Birds Eye for à la carte service, or for large banquets—you'll *know* your portion costs in advance! Why not test them today?

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Select, Medium,  
Jumbo  
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Wax Beans  
Lima Beans—  
Baby Green and  
Garden Run

Cauliflower  
Corn on Cob  
Cut Corn—  
Golden Bantam and  
Country Gentleman  
Squash

Spinach  
Green Peas  
Peaches  
Blueberries  
Raspberries  
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## Samples of Chinese and Foreign Full Diets

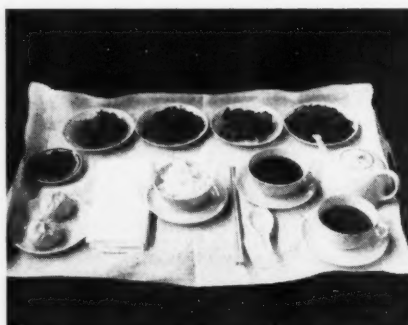
<i>Foreign—First Class</i>	<i>Chinese—First Class</i>	<i>Chinese—Third Class</i>
<b>Breakfast</b> Tangerine Oatmeal Eggs Bacon Jam Tea or Coffee Sugar and Cream	<b>Breakfast</b> Tangerine Jou Sung (minced salty dried pork) Hun Tun (dumpling with meat and soup) Millet Chou (millet porridge) Mantou (yeast risen bread made of wheat flour) Pa Pao Ts'ai (pickled vegetable) Tea	<b>Breakfast</b> Boiled Egg Sautéed Diced Pork With Dried Turnip and Bean Paste Millet and Sweet Potato Chou Mantou Salted Turnip
<b>Luncheon</b> Consommé Roast Lamb With Mint Sauce Riced Potatoes Carrots Julienne Buttered Spinach Tomato Aspic Salad Boston Cream Pie Rolls and Butter Tea or Milk	<b>Luncheon</b> Seaweed Soup Chicken Velvet With Minced Ham Sweet and Sour Pork Sautéed Bamboo Shoots With Shrimp Eggs Sautéed Yu Ts'ai (green vegetable) Lotus Seed Delight With Honey Dates Rice Mantou Tea	<b>Luncheon</b> Yu-pi Soup (bean curd skin) Sautéed Mengbean Sprout With Shredded Pork and Egg Sautéed Spinach Mantou Rice Rice Chou Salted Turnip
<b>Supper</b> Cream of Chicken Soup Fried Duck Liver Baked Potato Fresh String Beans Cauliflower Waldorf Salad Stuffed Persimmon Bread and Butter Tea or Milk	<b>Supper</b> Scallop With Sliced Turnip Soup Stewed Pork Tripe With Red Dates Sautéed Chicken Gizzard and Liver With Fungi Sautéed Fresh Mushrooms With Peas Sautéed Tai Ku Ts'ai (a kind of green vegetable) Almond and Red Fruit Jelly Rice Mantou Tea	<b>Supper</b> Braised Mutton With Carrot and Parsley Sautéed Pai Ts'ai (Chinese cabbage) Bean Milk Mantou Rice Chou Salted Turnip

time off for changing uniforms) with a half day off duty a week and a vacation of two weeks. All jobs are ranked on a sliding salary scale. A job analysis was made and definite duties were segregated. Although the labor turnover is still high it has decreased 40 per cent during the past year.

The kitchens are furnished with both imported and locally made equipment. As much native equipment as possible is used. Recently we installed native brick stoves that burn coal-balls. This has been found to be an effective economy measure since the heat efficiency of the coal-balls is as high as that of other types of fuel. The only drawback is that these coal burning stoves are much more difficult to keep clean.

Coal-balls are composed of 75 per cent anthracite dust mixed with 25 per cent wet clay. This mixture is molded into balls 1½ inches in diameter and dried in the sun to harden.

The coal-ball stove is constructed throughout of fire-brick and is finished at the front and ends in white tile. It comprises five large coal-ball fires. The firebox of each fire is bottle-shaped, 18 inches deep, and tapers from a diameter of 15 inches



Chinese first-class full diet tray.

at the bottom to 6 inches at the top or surface of the stove. Cast iron fire bars of an ordinary type with ¾ inch air space between the bars form the grate for each fire. In addition to the five large coal-ball fires, four additional 4 inch holes are provided on the surface to which heat from the fires is conducted by means of flues. Two heavy cast iron crescent-shaped blocks, 3 inches high, partly encircle the edge of each cooking hole; the clearance between the blocks provides free space for heat from the fire to cover the greater part of the surface of the cooking pot, which, in Chinese cooking, is generally of a semispherical form. Stoking of the fires and ash removal are done from the rear of the stove outside the kitchen for cleanliness. Only natural

draft is used under the fires in normal operation. In lighting up, when smoke from wood and coal-balls has to be emitted directly to the hood, an extension pipe from each fire to the interior of the hood is used to increase the draft. A fairly strong draft provided in the hood by means of induced draft fans effectively carries off fumes and heat from the stove.

Both Chinese and foreign food is served. An average daily census would show about 35 foreign full, soft and special diets, and 170 Chinese full and soft diets with an average of 140 Chinese special diets. The per capita cost for first-class patients is \$1.50 Mex. and for third-class, \$0.50 Mex. Special diets are of all types, the greatest proportion being for deficiency diseases. All special diets are modified from the regular full diet. The foreign food and Chinese food are prepared in separate kitchens.

The plate waste averages from 5000 to 6000 grams per day. This averages 21.4 grams per patient, which is very low. Even this is not wasted, however, as it is sterilized and given to the local Salvation Army headquarters for their soup kitchens.

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Fat . . . . .	2.0
Carbohydrates . . . . .	72.0
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<b>MINERALS:</b>	
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An average serving (20 grams) of Ralston contains about 30 International Units of vitamin B<sub>1</sub>. In addition, it is an excellent source of vitamins E and G and supplies natural bulk.

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# Food Clinic Proves Itself

MARTHA E. TARBOX

THE importance of diet as a part of the medical treatment of many diseases and the rôle of good nutrition as an aid in the prevention of disease are gaining increased recognition by physicians and the allied professions. The need for dietary control of the clinic patient is frequently as great as that of the hospital patient. The ambulatory patient is faced with many new and often complicated problems. There is usually need for him to change his long established food habits and he is too often confronted with lack of understanding and helpfulness on the part of friends and the members of his family group.

The object of the food clinic is to serve as a center for teaching outpatients and those about to be discharged from the hospital the diet that is such an important factor in their recovery and in their future maintenance of health.

The food clinic at the Pennsylvania Hospital, established in 1932, is situated in a room adjacent to the medical clinic, making it convenient for the physician and dietitian to discuss dietary prescriptions and their attendant problems. The decorations and furnishings have been chosen to create an attractive and homelike atmosphere, to educate and to appeal to patients of different nationalities.

The same procedure is used in referring patients to the food clinic as is used for all other clinics. The physician prescribes not only therapeutic but also normal diets. Many are referred by the social worker for guidance in budgeting their small incomes more wisely. The service of this clinic is available to free clinic, pay clinic and private patients referred by a physician. The charge is the same as for all other clinics and that for private patients is in keeping with other hospital services.

After admission to the food clinic each patient is encouraged to talk in detail about his food habits, par-

Miss Tarbox is the food clinic dietitian at the Pennsylvania Hospital, Philadelphia.



The dietitian explains the "sugar" value of foods to a diabetic patient.

ticularly the foods that he likes or dislikes. A careful record is made of a typical food intake for one day. Information regarding his family, his home life, working conditions and economic status is obtained. When necessary the social worker is consulted regarding her knowledge of the patient and his family. With this information as a basis, the dietitian plans the diet and presents it to the patient. The person who prepares the family meals, when it is not the patient, is often asked to come to discuss the diet with the dietitian.

The patient will follow his diet more carefully if he understands the reason for the particular one the physician has prescribed. He is told in simple terms something of the disease for which he is being treated and the relation of food to that disease. Wax models of common foods give a true picture of the amounts and kinds of foods that may be eaten. Samples of many other foods are kept close at hand to show the patient foods new to him or to overcome language difficulties that lead to misunderstanding.

In planning the diet the food habits of the racial group to which the patient belongs must be constantly kept in mind and as many customary foods as possible included. His individual food tastes are also considered so that, insofar as possible, the diet will consist of the foods he enjoys. New foods are introduced cautiously and are given with suggestions for their use, including appropriate recipes when necessary. The intelligence of the individual patient guides the dietitian in the entire procedure. Words and expressions are chosen carefully so that the patient may easily understand the instructions. No printed diet lists are given. A list of foods that may be used and those that are to be avoided is written as the diet is being discussed with the patient. The food intake for one day is divided into the required number of meals as a suggestion for the use of permitted foods. In planning the calculated diet as many substitutions as possible are given.

Patients suffering from diabetes mellitus are instructed concerning the nature of this disease, the amount

# METHODS FOR QUANTITATIVE ESTIMATION OF THE VITAMINS

## 1. The Determination of Vitamin D Activity

● About fifteen years ago it was clearly established that there could be present in certain foods or biological materials some substance which possessed antirachitic potency. Subsequently this "antirachitic factor" became known as vitamin D. Today, we know that at least ten sterol derivatives may exert antirachitic effects closely comparable to those of the originally discovered vitamin D (1).

Recognition of the existence of the antirachitic vitamin naturally stimulated investigation of methods whereby this dietary essential could be quantitatively estimated. Steady advances in knowledge of the causes and effects of rickets brought gradual improvements in these methods. Consequently, there are now available several techniques for the quantitative determination of vitamin D in foods or other biological materials.

The first and probably most widely employed method for estimation of vitamin D is by means of the so-called "line test" (2). In this technique as now employed (3), young rats are confined for 18 to 25 days to a diet conducive to development of rickets. These periods of time, with proper handling and confinement of the animals, are sufficient to induce a definitely rachitic condition. The rachitic rats are then properly grouped with respect to negative control groups to receive no supplements to the rachitic ration; positive control or reference groups to receive graded doses of some standard reference material; and "assay groups" to be given graded doses of the material under test. For the next 8 days the animals are fed daily doses of the proper supplement, either assay or reference material. No supplements are fed on the ninth and tenth days.

On the eleventh day the animals are sacrificed and either the proximal end of the tibia or the distal end of the radius or ulna dissected out, sectioned, cleaned and finally

immersed in silver nitrate solution. By double decomposition reaction, silver salts deposit where calcium is present in the metaphysis of the bone. When exposed to light these silver salts are reduced and form a dark line indicating the extent of calcium deposition. The experienced technician can estimate the degree of healing from rickets by the continuity and area of the line. By comparison of the results obtained on the various groups of animals, a quantitative expression of the antirachitic activity of the material under assay may be obtained.

A second method for evaluating vitamin D activity is that involving determination of "bone ash" (4). In this technique, final estimation of the degree of bone calcification—and thus the antirachitic potency of the substance under assay—is made by chemical analysis of specific bones of the experimental animals. A third assay method (5) is that involving roentgenological examination of certain bones. Comparisons of the bone densities of the various experimental animals serve as a basis for estimating the degree of healing from—or prevention of—rickets and hence permit determination of the vitamin D activity of the material under test.

Common foods as they naturally occur can hardly be considered as food sources of vitamin D. However, as exceptions, certain foods of marine origin (6) might be mentioned which consistently contribute small but definite amounts of the antirachitic factor to the diet. In addition, development of various means of fortifying foods with vitamin D—particularly those foods of importance in infant and child feeding—has made available other food sources of the vitamin (7). Among the many varieties of commercially canned foods will be found products of both types, which, when properly used or supplemented, should prove of value in obtaining an adequate intake of vitamin D, particularly by infants and children.

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- (1) 1938. J. Am. Med. Assoc. 110, 2150.
- (2) 1922. J. Biol. Chem. 51, 41.
- (3) 1936. The Pharmacopeia of the United States of America, Eleventh Decennial Revision, 482.

- (4) 1923. J. Biol. Chem. 58, 71.
- 1924. Ibid. 61, 405.
- (5) 1928. Biochem. J. 22, 135.
- (6) 1938. J. Am. Med. Assoc. 111, 528.
- (7) 1937. J. Am. Med. Assoc. 108, 206.

*We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the fifty-second in a series, which summarize, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.*



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

of sugar formed by the digestion and metabolism of various foods, the technic of insulin administration and food hygiene, as well as the kinds and amounts of foods that they may eat. When a patient has finished the discussion with the food clinic dietitian he should have a good general understanding of all the factors relating to the control of his disease and the protection of his health.

After completing the first interview the patient is given an appointment to return to the food clinic on the same day that he visits the referring clinic. On that day, after he has been seen by the physician, he returns for an interview with the dietitian. When necessary, the patient, often at the request of the physician, is seen more frequently. A careful check is made to determine how closely the patient has followed the instructions regarding his diet. Misunderstandings can often be clarified. Suggestions are offered as to new ways of using permitted foods and new foods are occasionally added. Advice regarding more economical purchasing of food is often needed. Different methods of appealing to the recalcitrant patient are tried. Diabetic patients are seen twice: once before they see the physician to check on diet and other factors relating to the disease, and again, to interpret any changes ordered by the physician.

An effort is made to disseminate information regarding good nutrition to the various groups that especially need such advice. Each day a class is conducted for prenatal patients who are making their second visit to the physician. During this class period the function of foods and their relation to pregnancy are discussed in order that the expectant mother may protect herself and her baby during this period. A class is also held during the dental clinic for children, which gives an opportunity to teach good nutrition while they are waiting to see the dentist.

Exhibits emphasizing the value of certain foods of low cost are placed in a conspicuous place adjacent to the food clinic where many patients who do not attend the food clinic may see them. Physicians, medical students, public health nurses and social workers also find these ex-

hibits interesting and instructive. Printed and mimeographed pamphlets, including recipes for the foods exhibited, are usually made available to all who are interested.

In these ways the food clinic has an opportunity to reach the majority of dispensary patients and present to them the relation of food to health.

Do the time and effort expended give fair returns? It is impossible to answer this question in terms of dollars and cents. The number of patients who, instead of requiring hospitalization, are able to continue with clinic treatment because of their contact with the food clinic is also impossible to estimate. We do know that only an occasional diabetic patient who is active in the food clinic is admitted to the hospital for standardization and very rarely is one admitted in coma. There has also been a marked decrease in serious infections.

The diabetic patient is not the only one who has profited because of his contact with the food clinic. Persons suffering from gastro-intestinal disorders, renal calculi, overweight and underweight are only a few who have benefited. Since the cost of medical treatment of clinic patients is much less than it is for the bed patient the hospital also profits. More beds are made available for the acutely ill.

In the majority of hospitals the need is felt for a dietitian in the out-patient department. Usually the therapeutic dietitian is called from her many duties to handle the diabetic clinic only; other patients requiring dietary treatment are frequently instructed by the busy physician. Under the stress of other matters he does not have sufficient time to discuss the diet with the patient, but resorts to a printed list that often leaves the patient confused and bewildered. In other instances the patient may be sent to the dietary department where a dietitian, rushed by the press of food preparation and tray service, does not have adequate time to discuss the diet in detail. Often the patient is told to avoid certain foods and is left in a quandary as to what he may eat. The failure to obtain the cooperation of the patient in such instances is the fault of neither the physician nor the

dietitian. It is because neither of them has time to explain the value of the diet to the patient or to adjust it to his individual situation. The patient feels that anything presented so hurriedly is of little value and he continues to eat foods that only aggravate his condition with the result that he must be admitted to the hospital for treatment. In many instances weeks of hospitalization are required before he is able to return to his home and clinic care. Had he been properly educated early in his illness the clinic visits might have been less frequent or the treatment of shorter duration.

During the past years of lowered hospital income no established food clinic has been given up. Administrators who have been responsible for maintenance cost and physicians who have had the aid of food clinics are unanimous in their opinion that it is an invaluable service.

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#### FOOD FOR THOUGHT

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• At a recent meeting on personnel management held in New York City, it was found to be the policy of the industries and institutions represented generally to promote persons from within the ranks. When relatives are employed they should work in different departments, since it has been found that too many from one family in an organization are disrupting.

When there is a personnel manager in an organization, heads of departments are generally given the final choice in employing and dismissing, but to avoid unfairness it is considered best for the discharged employee to have the final interview with the personnel manager.

All organizations represented in the meeting give vacations with pay and have either sickness insurance or hospitalization for their employees.

• Does cranberry juice appear on your beverage list? If not, it would be well to give it a try-out. Charlotte Sloan, dietitian at Stanford University Hospitals, San Francisco, describes it as a most attractive drink and one that is useful on acid ash diets. "A 10 ounce glass of cranberry juice a day," she says, "will give an acid urine with no diet restrictions." Miss Sloan also uses about 10 gallons of fresh orange juice a day as well as four gallons of tomato juice. Furthermore, she serves quantities of canned grapefruit and pineapple juice.



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# November Menus for the Small Hospital

## BREAKFAST

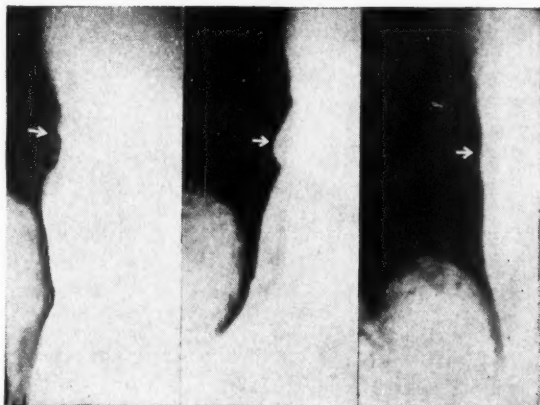
## LUNCHEON OR SUPPER

Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Desert
1.	Tomato Juice	Soft Cooked Eggs, Muffins	Cream of Celery Soup	Beef Loaf With Spaghetti Italienne		Red Cabbage and Walnut Salad	Orange Gelatin, Whipped Cream
2.	Stewed Prunes	Scrambled Eggs, English Muffins	Grilled Half Grapefruit	Rice With Olive Sauce	Parsley Cauliflower	String Bean Salad	Roll Jelly Cake
3.	Orange Juice	Jelly Omelet, Toast	Vegetable Soup	Devised Crab and Cabbage Salad, Russian Dressing	Fried Hominy Grits		Chocolate Pudding, Whipped Cream
4.	Pineapple Juice	Creamed Codfish on Toast	Tomato Bouillon	Eggs à la King With Buttered Noodles		Frosted Spinach	Silver Nut Layer Cake
5.	Sliced Bananas	Frizzled Ham, Cornbread	Seafood Cocktail	Sweet Potatoes Baked With Marshmallows and Bacon		Apple and Celery Salad	Pineapple Ice Cream
6.	Steamed Dates	Link Sausages, Toast	Cream of Corn Soup	Corned Beef Hash, Chili Sauce		Tossed Vegetable Salad	Strawberry Tart
7.	Half Orange	Bacon and Eggs, Bran Toast	Split Pea Soup	Baked Rice With American Cheese	Buttered Parsnips	Mixed Fruit Salad	Coconut Cookies
8.	Stewed Pears	French Toast, Syrup	Fresh Fruit Cup	Green Beans in Ham Cornucopias	Creamed Potatoes	Corn, Tomato and Green Pepper Salad	Vanilla Ice Cream
9.	Orange Juice	Poached Eggs on Toast	Grape Juice	Beef Stuffed Baked Potatoes	Celery Creamed With Almonds	Orange and Onion Salad	Sour Cream Pie
10.	Stewed Prunes	Coddled Eggs, Cinnamon Rolls	Essence of Carrot Soup	Fried Codfish Cakes	Escalloped Potatoes	Coleslaw	Baked Pear
11.	Canned Strawberries	Bacon and Apple Rings, Toast	Corn and Tomato Soup	Baked Hash	Sautéed Carrots	Waldorf Salad	Molasses Cookies
12.	Applesauce	Puffy Omelet, Date-Corn Muffins	Consommé Royale	Broiled Meat Balls	Mixed Vegetable Salad	Sauerkraut	Gingerbread, Whipped Cream
13.	Dried Fruit Compote	Baked Eggs, Cinnamon Toast	Cream of Lettuce Soup	Calves' Liver and Bacon	Hashed Brown Potatoes	Carrot, Pineapple, Lime Gelatin Salad	Apricot Refrigerator Cake
14.	Sliced Bananas and Diced Oranges	Sausages and Toast	Fruit Cocktail	Chipped Beef and Carrot Omelet	Buttered Green Beans	Tomato and Lettuce Salad	Lemon Pie
15.	Frozen Raspberries	Bacon, Eggs, Berry Muffins	Lentil Soup	Lamb Curry With Rice	Frozen Spinach	Celery and Olives	Berry Pie With Cheese
16.	Grapefruit Juice	Shirred Eggs, Muffins	Essence of Celery Soup	Pork Chops	Creamed Potatoes	Lettuce, French Dressing	Baked Apple, Cream
17.	Orange Juice	Soft Cooked Eggs, Toast	Oyster Stew		Baked Potatoes	Orange and Banana Salad	Butter Crunch Ice Cream
18.	Tangerines or Grapefruit	Poached Egg on Rusk	Tomato Cocktail	Chicken à la King on Toast	Buttered Brussels Sprouts	Lettuce, Russian Dressing	Cup Cakes
19.	Grape Juice	Scrambled Eggs, Toast, Preserves	Cream of Pea Soup	Corn Pudding and Bacon		Stuffed Prune Salad	Apple Dumpling
20.	Baked Apple	Bacon and Apple Rings, Pop Overs	Cream of Carrot Soup	Veal Loaf	Escalloped Potatoes	Tossed Salad	Brownies à la Mode
21.	Pineapple Juice	Wheat Cakes, Bacon, Syrup	Broiled Half Grapefruit	Baked Beans With Vienna Sausages	Boston Brown Bread	Sliced Tomatoes	Fruit Sauce, Cookies
22.	Sliced Bananas in Orange Juice	French Toast, Syrup	Cream of Potato Soup	Vegetable Plate: Cauliflower Hollandaise, String Beans, Grilled Tomato, Glazed Carrots		Cottage Cheese With Chives Salad	Chocolate Layer Cake
23.	Stewed Prunes	Puffy Omelet, Toast	Fresh Fruit Cup	Fried Calves' Brains, Tomato Sauce	Parsley Potatoes	Baked Tomatoes	Caramel Custard
24.	Tomato Juice	Creamed Fish Flakes on Toast	Cabbage and Potato Soup	Mushroom Omelet	Escalloped Onions	Waldorf Salad	Rice Pudding, Cream
25.	Orange Juice	Scrambled Eggs, Toast	Vegetable Soup	Cheese Fondue		Pear-Apricot Salad	Pineapple Up-Side-Down Cake
26.	Pineapple Juice	Bacon Omelet, Toast	Old-Fashioned Noodle Soup	Beefsteak Pie With Biscuit Crust	Buttered Lima Beans	Green Pepper and Pimiento Salad	Pistachio Ice Cream
27.	Dried Fruit Compote	Soft Cooked Eggs, Cornbread	Chilled Pineapple Cocktail	Bacon and Egg Croquette	Baked Potatoes	Sliced Beet Salad, Chiffonade Dressing	Fruit Gelatin, Whipped Cream
28.	Applesauce	Bacon and Eggs, Coffee Cake	Tomato Bisque	Baked Ham, Mustard Sauce	Escalloped Sweet Potatoes and Oranges	Buttered Cauliflower	Pineapple Tart, Whipped Cream
29.	Frozen Raspberries	Coddled Eggs, Toast	Grape Juice Cocktail	Filet of Sole With Lemon	Hashed in Cream Potatoes	Buttered Yellow Squash	Apple Scallop, Whipped Cream
30.	Orange Juice	Grilled Ham, Sweet Rolls	Cream of Corn Soup	Irish Stew With Dumplings	Fried Parsnips	Fruit and Pecan Salad	Eggnog Ice Cream

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

# Prompt Symptomatic Relief in PEPTIC ULCER

...with **PLAIN KNOX  
GELATINE (U.S.P.)**



**CASE I—FEMALE, 74**

Uncomplicated gastric ulcer first demonstrated by Roentgen rays in 1934. Diet and alkalis afforded little relief. Accompanied by loss of weight. Repeated X-ray studies in 1936 and 1937 showed no improvement. She was placed on a diet-gelatine regime in November, 1937. Relief immediate. Gained weight. Roentgen studies in April, 1938 showed no demonstrable ulcer.

**C**LINICAL research has recently demonstrated the effectiveness of utilizing plain Knox Gelatine (U.S.P.) in treatment of peptic ulcer. In a group of 40 patients studied, 36 (or 90%) were symptomatically improved; 28 of these (or 70%) experienced *immediate relief of all symptoms*. Other than dietary regulation which included frequent feedings of plain Knox Gelatine no medication was given except an occasional cathartic.

## NO DANGER OF ALKALOSIS

This regime thus eliminates the "alkalosis hazard" attendant upon continued alkali therapy. In discussing the mode of action by which gelatine brings peptic ulcer relief, Windwer and Matzner\* speak of the acid-binding properties by which proteins can neutralize acids, and they state that the frequent gelatine feedings "apparently caused more prolonged neutralization of the gastric juice."

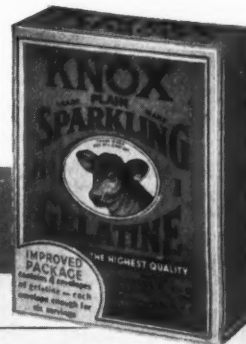
## PEPTIC ULCER FORMULA

Empty one envelope Knox Gelatine in a glass three-quarters filled with cold water or milk. Let the liquid absorb the gelatine. Then stir briskly and drink immediately before it thickens. Take hourly between feedings for seven doses a day.

\*Windwer and Matzner, *Am. Jl. Dig. Dis.* 5:743, 1939.

**NOTE:** The gelatine used in this study was plain Knox Gelatine (U.S.P) which assays 85% protein and which should not be confused either with inferior grades of gelatine or with sugar-laden dessert powders, for these latter products will not achieve the desired effects. When you desire pure U.S.P. Gelatine, be sure to specify KNOX. Your hospital can get it on order.

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## A Flask Washing Technic

R. M. PORTER

LIKE many advances in therapy the use of intravenous solutions has increased with great rapidity. During the past few years many procedures have been suggested as to the proper method of cleaning containers for these solutions. I have supervised the preparation of approximately 500,000 units of parenteral solutions and, with the exception of cleansing the flasks the first time with dichromate cleansing solution, I have used nothing except hot water as a cleansing agent.

The intent of this article is to point out the logic of this procedure. Cleansing agents, such as dichromatic cleansing solutions, soap and detergents, have been used for the routine cleansing of flasks, but the use of these agents is time-consuming as well as hazardous to the operator. When a flask is put into service it is

The author is assistant administrator of the Akron City Hospital, Akron, Ohio.

suggested that it be cleansed thoroughly with potassium dichromate sulphuric acid cleansing solution in order that any adherent flux or efflorescence may be removed. After cleansing with the dichromate solution, the flask should be rinsed repeatedly until all traces of the solution are removed. After this initial washing, it is my belief that hot water at from 160°F. to 170°F. is quite the proper cleansing agent.

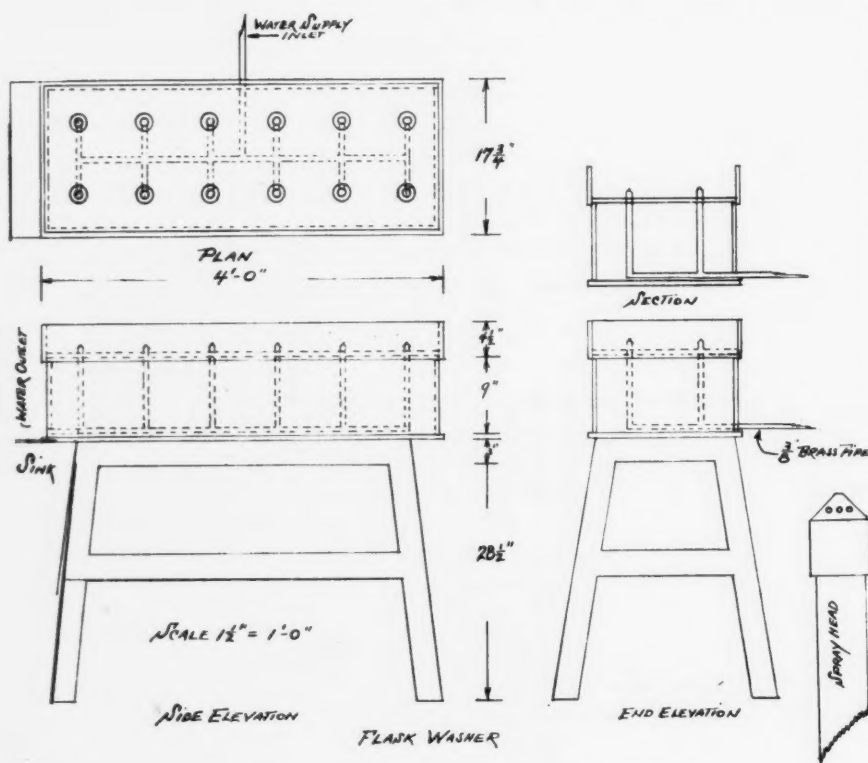
When we think of the term cleansing, we immediately affix in our minds a process wherein we free the surface to be cleansed of any adherent substances by one of three methods: (1) by the removal of soluble substances with a solvent in which the substances are soluble; (2) by the action of an oxidizing or reducing agent to enhance solubility,

or (3) by the use of an emulsifying agent in cases of insoluble substances, and the subsequent mechanical removal of the emulsified substances.

This last mentioned procedure is often facilitated by the use of a detergent that causes a physical disintegration of the particles, thus facilitating the emulsification of the particles by the soap. At the City Hospital, Akron, Ohio, we generally use potassium dichromate sulphuric acid cleansing solution as an oxidizing agent. The most commonly used emulsifying agent is soap. Water is used to remove a soluble substance when the substance is water soluble. When the substance is not water soluble, we use such other solvents as benzine, acetone, alcohol or ether.

Intravenous solutions are in all instances water soluble substances, the solubility of which is greater in hot water than in cold. For this reason we may well ask why we should introduce another foreign substance that must also be removed, in addition to the already present contaminant. Soap is not so readily removed from a surface of glassware as one might think. I have seen flasks of dextrose after autoclaving, with a decided amber color traceable to the fact that the flasks were previously cleansed with soap solution and not thoroughly rinsed. Such contamination is possible even though it is rare and may cause febrile reactions in the patients to whom the solution is administered.

The dichromate solution has but one advantage, which is that it will remove any foreign oxidizable substances, such as bacteria. However, my experience has been that the danger of bacterial growth may be reduced to a minimum if one insists upon the immediate return of the



Intravenous Solutions

# Intravenous Solutions in Filtrair Dispensers



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*Incorporated*

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flasks after the administration of the intravenous solutions. It is true that the return of the flasks within twenty-four hours, like any other hospital procedure, requires a certain amount of supervision. The caps or stoppers, of course, should be replaced in the flasks immediately after administration of the fluid and the flasks should be rinsed as soon as they have been received in the pharmacy or laboratory so that all foreign matter or the growth of air-borne or other bacteria is removed from them for all practical purposes.

The dichromate solution is extremely caustic and attacks practically anything that it touches, including the operator's hands, and in too many instances it is spilled and not immediately removed. It is certainly a solution that should be employed only when absolutely necessary. Many a maid working around the laboratory has been disfigured by spilling dichromate cleansing solution or coming into contact with laboratory tables and shelves on which the liquid has been carelessly spilled.

#### Model of Flask Washer

The sketch accompanying this article shows a working model of the apparatus used in our pharmacy to wash intravenous flasks. This equipment is so constructed as to afford a spray of water in the interior of the flask so that the entire surface is irrigated. The water flow is controlled by a foot pedal. The hot water service for the house is connected to the foot-operated valve. The operator treads the foot pedal on the valve in such a manner as to give numerous sprays of hot water at a temperature of 140°F.; the flask is automatically drained after each operation. This operation is comparable to one of the first axioms the analytical chemist learns in his study of analytical procedures, *i.e.* that numerous washings with a small quantity of liquid are preferable to and more efficacious than fewer washings with much greater quantities of liquid. The amount of tap water that adheres to the sides of the flask after draining for a period of a few minutes has been determined to be less than 1/120 of 1 per cent of the entire volume of the flask, hence, I

see no reason for rinsing with distilled water. In our local raw water supply we have 14 grains of hardness to the gallon and when we calculate

this through to the finished solution, we find we have a contaminating figure of 1:80,000,000. This can be determined for any water supply.

## The Physician and the Pharmacist

JOSEPH A. BARRY

COOPERATION between the pharmacist and the medical staff of the modern hospital is of vital importance, first, because it safeguards the patient, and second, because it is a matter of economy for the hospital.

In order to command the attention of the staff members, the pharmacist must keep well informed on all the newer chemical and drug compounds of any importance that appear periodically on the market. To this end he should have or should acquire a good, complete reference library so that he may, at a moment's notice, disseminate valuable information to the physician. The assumption that a physician resents having his attention called to something other than he has prescribed is erroneous. He has the earnest desire that his patient shall receive the most beneficial remedies available and will be appreciative of any suggestion to that end.

After all, how can a doctor memorize and know definitely the composition and different potencies of the thousand and one preparations that are constantly being placed on the market? For instance, the therapeutics of the estrogenic hormones will serve to illustrate this point. The direct comparison of estrogenic products on a "unit for unit" basis is impossible in view of the fact that different laboratories use rats of different ages, take different end points of assay and express rat units in different terms of the total amount of hormone used in assay. A quick perusal of the vitamin compound market will also prove the futility of trying to remember whether the product of one manufacturer is really as potent as that of another. In the capsule form one manufacturer will

express the vitamin units per gram while another will express his units per capsule. Then the physician and pharmacist must determine the amount contained in one capsule, whether it is a three or five minim, to ascertain the real vitamin value.

In this connection it is hoped that in the near future any new compound before being exploited will be required to have the approval of the U. S. Department of Agriculture and to be accepted as a new and nonofficial remedy by the American Medical Association. The action the government has taken lately in regard to proper research being conducted before releasing new potent chemicals must be commended.

As a measure of economy to the hospital the cooperation of the pharmacist and the several staffs is imperative. By consulting our laboratory director we have saved hundreds of dollars a year. We have eliminated several high priced germicides and disinfectants after tedious and thorough laboratory tests proved that lower priced ones were as effective.

It can be seen that if such cooperation is established the end result, as has been demonstrated in many institutions, will be a pharmacy that is up to the minute in new therapy; a constant elimination of "repeats" and nonessential drugs; a reduced inventory with greater room for the addition of efficient new items, and an economy that constantly results in a profit throughout the hospital and also in the outpatient department if there is one.

Finally, the pharmacist must be considered a vital part of the modern hospital and should be consulted by the different members of the staff when the occasion requires. Only in this way will the patient receive the utmost in medication, and the hospital, the ultimate in economy.

Mr. Barry is the pharmacist at the Memorial Hospital, Worcester, Mass.

# 12

# Reasons why!

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# #

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9. Assures a more normal fecal consistency.
10. Less likely to leak
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*Petrolagar — Liquid petrolatum 65 cc. emulsified with 0.4 Gm. agar in a menstruum to make 100 cc.*



# Petrolagar

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# Sugar Coating Medication

MARGARET PEARSON

THE children of a generation ago, as well as their elders, were forced to swallow concoctions that might well have made the strongest quail. Remedial agents were then thought to have little value unless they were bitter and unpleasant to swallow. Thus, dark brown medicine, with a darker brown taste, sulphur and molasses and bitter herbal decoctions found honored places in the medicine cabinets of those days. With such an armamentarium the prevailing theory seems to have been the worse the taste, the quicker the cure.

Today that story is changed. As the skillful chef carefully blends his spices and savories to delight the taste, so modern pharmaceutical manufacturers tempt the eye and trick the palate. Yearly, a considerable amount of time and money is spent in research on this matter of sight and taste appeal. The result is that the newest medicinal offerings are masterpieces of blending and disguise. The official formularies, too, offer a wide range of flavoring and coloring agents so that with a little trial every medication can be made quite tempting. Dr. Bernard Fantus has made exhaustive studies to determine the best vehicles for various remedial agents. By carefully following the suggestions given in those studies and experimenting extemporaneously from time to time, medications can be made that will tempt the most fastidious child.

The sick child in the home, however, may be fretful and prejudiced against even the most attractive medications offered. Here varied additional measures are necessary. The use of honey, because of its viscosity and sweet taste, is most effective. Doctor Fantus also mentions the use of maple syrup in this connection. Then, too, the many fruit juices now available, both fresh and canned, are valuable aids to perfect disguise. However, it might be well to consider the indiscriminate use of milk.

Miss Pearson is the pharmacist at the Children's Hospital, Washington, D. C.

Milk is an important and extremely valuable article of food and its misuse as a vehicle for medicines might lead to a permanent distaste for it.

A popular device to make doses more pleasant for adult consumption is the use of seltzer or carbonated water. The tingling effervescence of medicine offered in this guise is well known to all. With children the substitution of a flavored carbonated beverage, or "soda-pop," should by its very association with childhood make the dose-taking a happy event instead of an onerous duty.

Candy medication is another rational, though seldom used method of approach. As early as 1912, Doctor Fantus advocated this method as being the ideal one with which to combat the "spoon-and-pill" bugaboo. To further this ideal he even went so far as to learn the candy-maker's art. Then he was able to bring forth a considerable number of formulas for the manufacture of sweet tablets. At the present time

"The Pharmaceutical Recipe Book" contains a number of these formulas.

The chief objection to this form of administration lies in the danger of accidental poisoning when unused portions remain after treatment. The answer to this problem is the same as it is to that of keeping any unused medicines, *i.e.* they should be kept well out of the reach of children. An interesting departure in this same connection is the use of lolly-pop tongue depressors. A commonplace tongue blade, one end thinly coated with a pure fruit hard candy, serves a two-fold purpose: first, its normal use, then as a reward for good behavior and cooperation.

Administration of remedial agents to children in the form of powders has long found favor. Here, however, the use of "oil sugars" takes preference over plain sucrose or lactose. Since they are mixtures of sugar and volatile oils their masking action is quite effective. The sweetness of the mixtures and the ease of administering them even to small children make them deservedly popular with patients of all ages.

## NOTES AND ABSTRACTS

By Carl C. Pfeiffer, M.D., Department of Pharmacology  
University of Chicago

### Excess Vitamin C Therapy

- With the identification of vitamin C as ascorbic acid many new uses have been found for the product, not as a vitamin but as a drug. That is, doses are used in excess of those that could be justified in dietary deficiency alone.

**Lead Poisoning.** Holmes and his co-workers at Oberlin College have studied the effect of high doses (from 100 to 200 mgm. daily) of vitamin C on the symptoms of lead poisoning. They found that painters who suffered from lead poisoning were much improved as far as nervous tremors, insomnia and general malaise were concerned. The urinary lead excretion was markedly decreased, while an increase in the fecal lead excretion was assumed to have taken place. The authors indicate that according to test tube experiments the vitamin C forms a poorly ionized and

less toxic compound with the lead, which can then be excreted by way of the liver. Painters who were in the habit of taking large quantities of vitamin C in their diet did not show any symptoms of lead poisoning although they had been equally exposed to the source of lead.

**Thyrototoxicosis.** While studying the effect of vitamin C on excess creatinuria resulting from self-administered thyroxine, Plehiv of the University of Heidelberg noted a marked amelioration of the subjective symptoms of hyperthyroidism. This led him to try this therapy on thyrotoxicosis patients. The basal metabolic rate was slightly reduced, but the greatest change was noted in the subjective symptoms. The patients were much less apprehensive and the creatinuria disappeared.

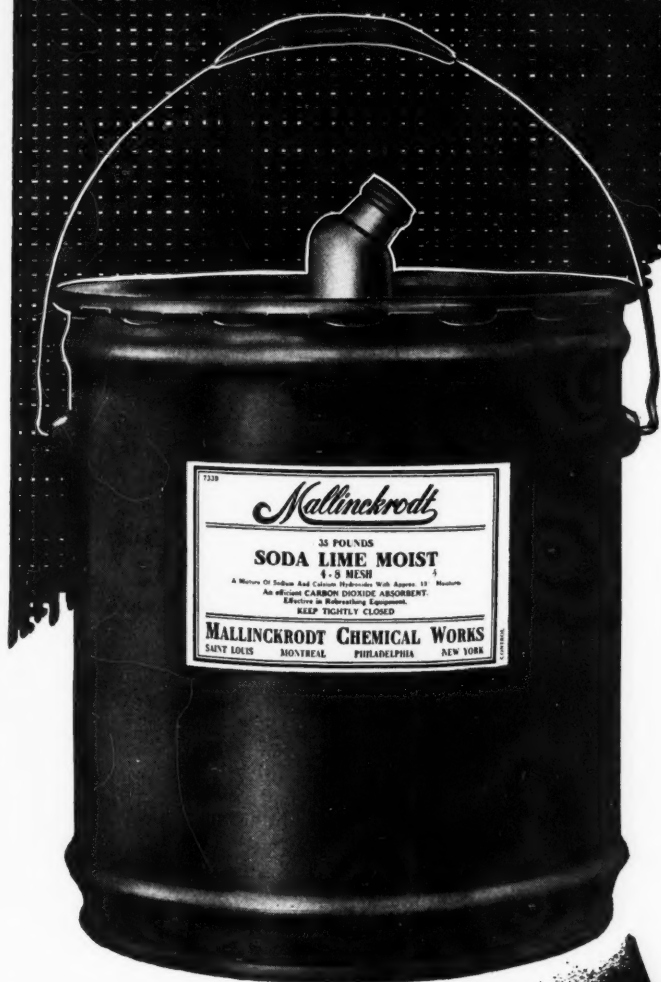
(Continued on page 120)

# 5 REASONS

WHY YOU SHOULD USE MALLINCKRODT'S

## New SODA LIME MOIST

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OXYGEN TENTS  
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- 2 **IMPROVED POROSITY** . . . porous structure of the granules results in rapid, long sustained and efficient absorption of carbon dioxide.
- 3 **LARGE SURFACE EXPOSURE** . . . "Knobby" surface of granules provides large area for effective absorptive action.
- 4 **ROUNDED SHAPE AND STANDARDIZED SIZE** . . . More rounded shape and standardized size prevent packing of the granules in the apparatus—assuring free air flow.
- 5 **LONG-LASTING STABILITY** . . . The components, sodium hydroxide, calcium hydroxide and moisture content are carefully balanced so that even with prolonged use, the granules resist gumming or caking.

SODA LIME MOIST in 4-8 and 8-14 mesh sizes can be obtained in 7 and 35 lb. containers.

Economy size container has special pouring spout which prevents spilling and a reclosing cap which tightly reseals the container. The handle of the pail has a wide flange grip which makes for ease in carrying, even when full. When empty, the cover is easily removed and the container becomes a convenient pail for hospital use.

A trial can of SODA LIME MOIST will be sent free of charge. See the improved size and shape of the granules, manufactured to furnish maximum absorbing capacity. Note comfort for the patient. Respiratory embarrassment is minimized because of improved physical structure—allowing air to flow more freely through the apparatus.

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Please send trial package of the new SODA LIME MOIST.

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Street \_\_\_\_\_  
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We generally use (check) ☐ 1 gallon size ☐ 5 gallon size

## NOTES and ABSTRACTS • • •

(Continued from page 118)

**Excited States.** The depressive effect of large doses of vitamin C has also been demonstrated at several psychiatric institutions where it has been found that some maniacal patients may be adequately controlled by large (1.0 gm.) doses of ascorbic acid administered intravenously. While the expense of such therapy is far in excess of the usual cost of sedative therapy, it serves to demonstrate the possible sedative action of ascorbic acid. That the patients relapse when the massive doses are discontinued is an indication that this is excess vitamin therapy rather than treatment of vitamin deficiency.

**Paroxysmal Hemoglobinuria.** This rare disease, which usually occurs only in syphilitic patients and is thought to be due to a specific hemolysin, has responded to large doses of vitamin C given orally. Lotze and also Armen-tano and Bentsath, working in Germany, report that patients who would ordinarily have marked hemoglobinuria when exposed to cold will be immune to temperature changes if the dietary level of vitamin C is increased.

**Addison's Disease.** A decreased skin pigmentation in patients suffering from Addison's disease has been universally observed if the patient is treated for a sufficient length of time, according to Abt and Farmer. Schroeder and Einhauser, working in Germany, gave 300 mgm. daily intravenously for two weeks to a pernicious anemia patient and noted a decreased facial pigmentation. Abt and Farmer in Chicago have noted a mottled depigmentation below the eyes of a Negro given a daily oral dose of 450 mgm. over a period of several months. Vitamin C in large doses, therefore, interferes with the normal and pathological deposition of melanin but does not improve the other symptoms of these diseases.

**Diabetes Mellitus.** Following the work of Sigel and King of Pittsburgh, who noted a decreased dextrose tolerance in scorbutic guinea pigs, Pfleger and Scholl, working in Germany, have found that diabetic patients, if saturated with large doses of vitamin C, could be more easily controlled with smaller doses of insulin.

### Nicotinic Acid and Radiation Sickness

• Spies, Bean and Stone in Cincinnati noted porphyrinuria in five out of seven

cases of radiation sickness and accordingly tried nicotinic acid therapy, which resulted in prompt relief of the symptoms and a cessation of the urinary porphyrin. Graham in Toronto has extended their studies, and although he cannot confirm the findings regarding porphyrin, he agrees that nicotinic acid therapy is much more effective than any treatment previously used. In a series of 70 cases he obtained definite relief in 74 per cent of the patients. This is better than the relief obtained by pentobarbital or intramuscular liver extract. While these students appear to disagree as to the rôle of the porphyrins in causing the syndrome, nevertheless, they clarify the therapy of this disorder.

### Nicotinic Acid and Pruritus

• Dabney of Birmingham, Ala., has been using nicotinic acid in the treatment of pruritus of unknown origin after all of the known causes of pruritus had been ruled out. Four of the eight women obtained complete relief from pruritus vulvae, including two who also had pruritus ani. The average duration of the condition in the women who were relieved was fourteen months, whereas the unrelieved patients had suffered for an average of six years. It is believed that the dose of nicotinic acid that was given, 100 mg. three times a day after meals, was far too large and that it caused several unpleasant, though harmless, reactions. Hereafter, the dosage will be 20 mg. three times a day, and this amount will be increased only when it is deemed necessary.

### Nicotinic Acid and Sulfanilamide

• McGinty and his co-workers in Atlanta, Ga., have treated sulfanilamide reactions with nicotinic acid (50 mgm. T.I.D.). Their program was to institute nicotinic acid therapy on the fourth day of the sulfanilamide treatment. Quantitative determinations for sulfanilamide were made daily on the blood and urine by the method of Marshall and Litchfield, and the urine was studied for porphyrin excretion. The patients responded to the nicotinic acid therapy by a decrease in their untoward sulfanilamide symptoms, a clearing of their mental apathy and a decrease in their porphyrinuria. Since sulfanilamide may act on the bacteria by decreasing their essential food elements,

the action of nicotinic acid should be evaluated with regard to any decrease in the therapeutic effect of sulfanilamide when administered simultaneously with nicotinic acid. Saunders of Chicago has recently shown that nicotinic acid is an essential food element of many bacteria.

### Vitamin K

• The existence of vitamin K was first suspected about nine years ago when Dam of Copenhagen experimented on the lipid metabolism of day old chicks. These chicks were placed on a fat-free diet and, after several weeks, developed hemorrhages in the skin, the mucous membranes and other portions of the body. This work prompted the discovery of a new fat-soluble vitamin which, because it had to do with "Koagulation," was given the name, vitamin K.

This vitamin has been shown to be necessary for synthesis of prothrombin in the liver. Mammals obtain vitamin K both in the diet and by bacterial action in the small intestine. A vitamin K deficiency may result from faulty absorption of this fat soluble substance from the intestine. Hence, bile salts are always given with the vitamin to facilitate absorption. The use of vitamin K in obstructive jaundice was first proposed by Quick of Milwaukee on entirely theoretical grounds. Greaves and Schmidt provided the necessary experimental data which proved that a true K deficiency existed in jaundiced patients. Smith and his co-workers at Iowa City, Ia., first used this vitamin successfully in jaundiced patients and demonstrated that prothrombin is manufactured in the liver. In spite of marked impairment of the liver, as shown by all of the clinical tests for liver function, only occasional patients are unable to manufacture prothrombin if given vitamin K. The drug is ineffective in hemophilia.

The dosage is as yet indefinite since the pure crystalline material is still in the experimental stage. However, usually from 200 mgm. to 8 gm. of the crude concentrate is given by mouth daily with from 2 to 4 grams of bile concentrate or bile salts.

The most recent work of MacCorquodale and his co-workers in St. Louis has indicated that this vitamin is 2-ethyl-3-phytyl-1, 4-naphthoquinone. Since other workers have also found that this substance contains the naphthoquinone group, the St. Louis workers are probably correct. The development of a pure compound for intramuscular use will be awaited with interest by the medical field.



Little hero of Holland, eight-year-old Peter, who all night long, although cold and exhausted, kept his tiny hand over a hole in the dyke and held back the sea from his beloved land.

## Forestall a Crisis

When the blood pressure begins to drop, support the patient with a subcutaneous injection (average dose 0.5 cc.) of

One Per Cent Sterile Solution of

### Neo-Synephrin Hydrochloride

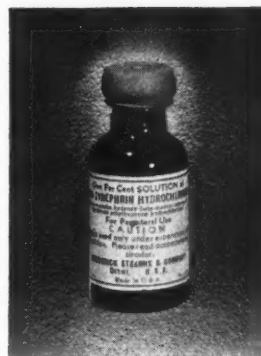
(laevo-alpha-hydroxy-beta-methyl-amino-3-hydroxy ethylbenzene hydrochloride)

This valuable synthetic vasoconstrictor is of considerable usefulness in the treatment of acute hypotension due to trauma, hemorrhage, anesthesia (particularly spinal) and "surgical shock."

**Sustained Pressor Action**—The rise in blood pressure following subcutaneous injection of Neo-Synephrin Hydrochloride usually lasts from one to two hours.

**Effective When Repeatedly Injected**—Neo-Synephrin Hydrochloride may be repeatedly administered without an appreciable decrease in its pressor effect. This is in sharp contrast to ephedrine, which, if repeatedly injected, may be followed by a decrease, disappearance or reversal of the pressor action.

**Low Toxicity**—Neo-Synephrin Hydrochloride in therapeutic doses is less toxic than either ephedrine or epinephrine and in comparison with these it has a wide margin of safety.



In the doses recommended Neo-Synephrin Hydrochloride usually does not produce nervousness or apprehension.

Supplied in rubber-capped vials containing 15-cc. of a sterile 1% solution.

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# Monthly News Review

Vol. 53

October 1939

No. 4

## 1500 Attend American Congress on Obstetrics, Gynecology in Cleveland

The first American Congress on Obstetrics and Gynecology met in Cleveland, September 11 to 15. More than 1500 doctors, nurses, public health representatives and institutional administrators, representing every state in the Union, Canada, Alaska, Hawaii, the Philippines, Cuba, Puerto Rico, Panama, Brazil, England, Ireland and the Netherlands attended the sessions.

Problems of maternal and new-born infant care were discussed in detail in separate meetings of each group and in joint sessions for the common problems of all groups.

Outstanding leaders in the practice and teaching of obstetrics and gynecology were represented in the five day discussions.

Dr. Fred L. Adair, chairman of the department of obstetrics and gynecology at Lying-In Hospital, University of Chicago, was general chairman of the congress.

The scientific and educational exhibits were under the direction of Robert D. Mussey of the Mayo Clinic and presented the finest collection of research ever assembled on the subject of human reproduction, maternal and new-born infant care.

Four evening meetings were thrown open to the public. Seven thousand persons saw the moving picture, "The Birth of a Baby," on the first evening program, and more than 5000 heard Dr. Allan Dafoe tell the story of how the Dionne quintuplets, weighing collectively 10½ pounds at their premature birth, were cared for and developed into strong, sturdy children. Pictures taken the first day of birth and on successive days and weeks were shown on the screen for the first time to a large audience.

Wednesday evening Dr. Maud Slye, professor of pathology, University of Chicago, spoke on cancer and heredity. The final evening meeting was addressed by Mrs. J. K. Pettingill, president of the National Congress of Parents and Teachers on the subject "Lay Education in Maternal and Infant Care."

The next congress will probably be held in 1942.

AVERAGE DAY AT ST. LUKE'S		
<b>OPERATIONS</b>  18 PER DAY	<b>BIRTHS</b>  3 PER DAY	<b>X-RAY EXAMINATIONS AND TREATMENTS</b>  41 PER DAY
<b>PHYSIO-THERAPY</b>  22 PER DAY	<b>PATIENTS</b>  27.9 PER DAY	<b>MEALS</b>  2400 PER DAY
<b>ADMISSIONS</b>  28 PER DAY	<b>MEAT</b>  735 LBS. PER DAY	<b>MILK</b>  139 GAL. PER DAY
<b>LAUNDRY</b>  3 TONS PER DAY	<b>FUEL</b>  30 TONS PER DAY	<b>SOCIAL SERVICE VISITS</b>  104 VISITS PER DAY

A pictorial analysis of an average day at St. Luke's Hospital, Chicago, taken from the 1938 annual report of the hospital, which is celebrating its 75th anniversary.

## Dietetic Association Meets in Los Angeles; 1000 Attend

Mary I. Barbour, director of home economics of the Kellogg Company, Battle Creek, Mich., was named president-elect of the American Dietetic Association at the annual meeting held in Los Angeles, from August 27 to September 1. Mrs. Beulah B. Marble of the Huntington Memorial Hospital, Boston, was installed as president; Angeline Phillips, University Hospital, Omaha, Neb., was reelected secretary, and Margaret Cowden of Michael Reese Hospital, Chicago, was named treasurer.

Among the speakers at the various sessions were: Agnes Fay Morgan, Ph.D., chairman of the division of home economics, University of California, who discussed "The Dietitian's Place in the Hospital Research Program"; Kathryn Tissue, professor of dietetics at the University of Kansas, speaking on "Diet and Resistance to Tuberculosis," and A. C. Jensen, superintendent of the Fairmont Hospital, San Leandro, Calif., whose topic was "Broadway Horizons."

## Expanded Nursing Program, New X-Ray Courses to Be Given at N. Y. University

With the assistance of five public health organizations, the School of Education of New York University is planning to conduct a greatly expanded program of nursing education during the coming academic year. The New York State Department of Social Welfare, the American Red Cross, the Jewish Hospital of Brooklyn, Beth Israel Hospital and Kings County Hospital, New York, will cooperate with the university in a program of 44 courses for graduate and undergraduate students in public health work, institutional nursing, home nursing and school nursing. Most of the courses will be given in the evenings and on Saturdays at the cooperating hospitals and at the university's Washington Square Center.

The university's division of general education is offering two evening courses on x-ray technic, which are open to nurses, laboratory technicians and others whose work requires a knowledge of x-rays. The courses, conducted by Prof. H. H. Sheldon, will include laboratory work in medical, dental and metallurgical radiology; the measurement of high voltages, and x-ray intensity and positioning.

## Mount Sinai Hospital to Train Social Service Aids

To increase the ability of its clinical volunteers, Mount Sinai Hospital, Philadelphia, has announced the inauguration of a free training course open to all women interested in medical social service. Completion of the brief course will be a prerequisite to admission into the social service department of the hospital as a clinical volunteer.

Pauline Schiff, director of social service, will give three lectures. The first will be devoted to various phases of maladjustment; the second will describe the rôle of social service in hospitals generally, and the third will deal with the administration of the social service department of Mount Sinai. A tour through the hospital will close the instruction schedule. The course is being sponsored by the junior women's auxiliary.



## *THERAPY WITH THE BARBITURATES*

● In surgery, in obstetrics, and in general practice, barbituric acid derivatives have a wide field of usefulness. Prominent among those favorably received by the medical profession are:

**'AMYTAL'** (Iso-amyl Ethyl Barbituric Acid, Lilly). Sedative and hypnotic.

**'SECONAL'** (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly). Because of the short duration of the effect of 'Seconal,' the patient remains under constant control.

**'SODIUM AMYTAL'** (Sodium Iso-amyl Ethyl Barbiturate, Lilly). Hypnotic and anti-convulsant.

*Professional Inquiries Invited* • **ELI LILLY AND COMPANY**

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.



Prominent among the "faculty" of the seventh annual institute for hospital administrators held at the University of Chicago were Dr. G. Harvey Agnew, Dr. Malcolm T. MacEachern, Dr. William H. Walsh and Dr. Bert W. Caldwell. These gentlemen, along with other familiar faces and figures, may be seen in the front row of this photograph.

## S'WIPE'S\*

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S'WIPE'S\* are fair trade priced and you can obtain them through any Supply Dealer. Send to us for samples and prices which we will gladly supply; and your order can be placed through your Supply House. All items shown above can be shipped from stock.

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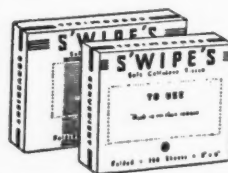
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FLAT:	Size	Packed
	5x 6	33,600 sheets per carton
FOLDED:	5x 9	32,400 sheets per carton
	4x 6	36,000 sheets per carton
FOLDED:	5x 6	28,800 sheets per carton
	6x 6	24,000 sheets per carton
	5x 9	32,400 sheets per carton
	9x10	10,000 sheets per carton
	9x15	8,000 sheets per carton
	15x18	4,000 sheets per carton

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#### FLAT STYLE

Size	Sheets Per Box	Boxes Per Carton
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5x 6	400	72



#### FOLDED

Size	Sheets Per Box	Boxes Per Carton
4x 6	200	120
5x 6	200	96
5x 6	200	150
6x 6	200	80
5x 9	50	144
5x 9	100	100
5x 9	100	144
5x 9	100	200
5x 9	136	144
5x 9	200	72
5x 9	200	100
9x10	500	36
15x18	75	36



#### INTERFOLDED TISSUES

5x 9	136	144
9x10	136	72
9x15	150	36

#### COMBINATION

9x10—5x9	150 sheets each	36 per box
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# SCRIVEN ADJUSTABLE BED TABLE

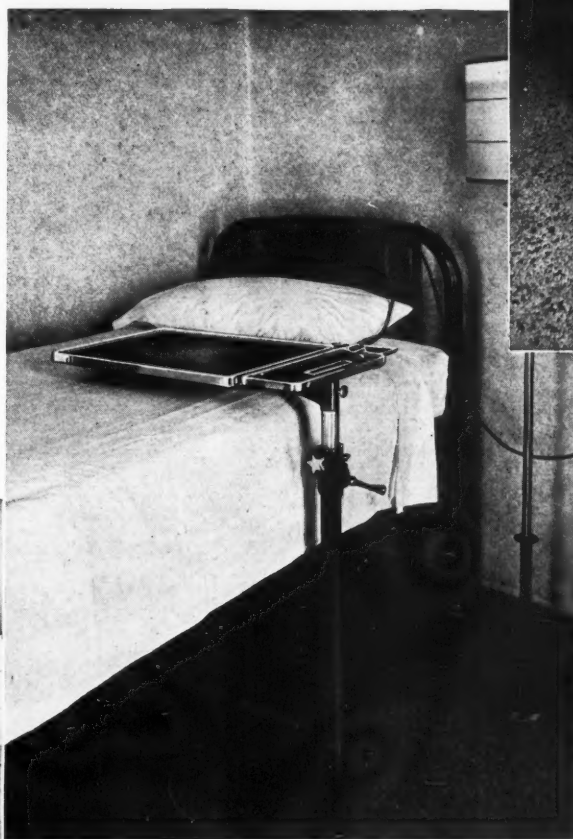
*"It has Everything"*

The Scriven Table is unique, entirely new, intensely practical . . . incorporating many exclusive features:

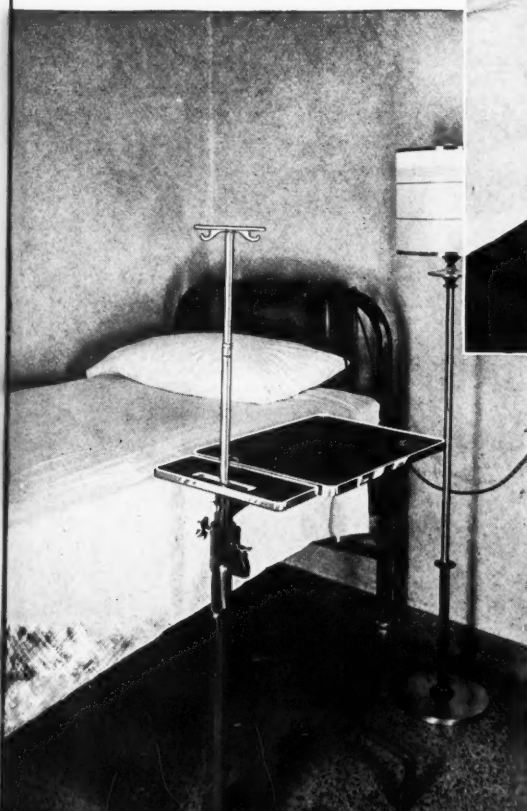
- CANNOT TIP OR UPSET . . . protection against damage suits.
- EASILY ADJUSTED to any position over or beside the bed.
- TABLE CAN BE FLAT OR TILTED at any angle. Safety automatic catch prevents table from slipping when in proper position.
- SINGLE TABLE FRAME leaves the other side of the bed free for doctor or nurse.
- TABLE TURNS IN COMPLETE CIRCLE, with the foot member always directly below to act as a counterbalance. When beds are close together, table can be used over either bed.
- IRRIGATING STANDARD raises to 72 inches and telescopes out of sight when not needed.
- REMOVABLE ASH TRAY snaps on to either side or end of tray, easily removed.
- RUBBER WHEELS WITH SWIVEL JOINTS on foot members operate quietly and smoothly.



TOP PHOTO: Thin metal plate under leg of bed holds table securely. Note table tilted for reading, leaving side tray stationary for personal effects, etc.



CENTER: Patient in bed, or nurse, can raise and tilt the table for reading, or lower it flat over the bed for eating, as shown.



BOTTOM: Here the telescoping irrigating standard is raised for convenient use, and the table lowered beside the bed for the nurse's utensils.

- HEAVY STEEL CONSTRUCTION throughout, practically indestructible. Table tops are aluminum covered with Battleship linoleum.
- DUCO ENAMEL FINISH in a variety of colors to harmonize with the room's furnishings.
- ECONOMICAL . . . low initial cost. Ideal for replacements.

SPECIFICATIONS: Table top —16"x22", side tray —5½"x14". 1⅝" apron around each unit and ½" lip around tray and on sides of table prevent dishes from slipping off and support reading matter.

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**SCRIVEN BED TABLE COMPANY**

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SOUTH DAKOTA

MH 10-39

### El Paso Council Elects Officers

Mrs. Margaret Schuster Marshall, of the Providence Hospital, El Paso, Tex., was elected president of the El Paso Hospital Council at a recent meeting of the association. Mrs. Marshall succeeds A. Edward A. Hudson, superintendent of the El Paso Masonic Hospital, who organized the council and served as its first president. Sister Sienna, administrator of the Hotel Dieu, was reelected vice president. The council voted to take advantage of and support the Non-Profit Group Hospitalization of Texas, Inc.

### Council Approves Hospital Plan

A resolution approving the plan of the Group Hospital Service, Inc., of Texas was passed by the Dallas County Hospital Council, which also urged employers to take advantage of the cost service offered to employees. Bryce Twitty, who is in charge of the service, explained the plan in detail and the resolution was adopted by the council.

### New Hospital for Greenwich

The board of directors of the Greenwich Hospital, Greenwich, Conn., has announced plans for a new six story building to be erected near the site

of the present hospital. The existing structure will be converted into living quarters for the staff. The new hospital will be so designed that it may be enlarged from time to time as may be required in order to provide for a maximum of approximately 300 beds. The cost is estimated at \$1,020,000.

### Coming Meetings

Oct. 16-20—American College of Surgeons, Philadelphia.  
Oct. 26-28—National Society for the Prevention of Blindness, Astor Hotel, New York City.  
Nov. 20-21—Alberta Hospital Association, Edmonton, Canada.  
Dec. 8-9—Kansas State Hospital Association, Jayhawk Hotel, Topeka.  
Feb. 22-24—Texas Hospital Association, San Antonio.  
March 7-9—New England Hospital Association, Hotel Statler, Boston.  
March 28-30—Southeastern Hospital Conference, Edgewater Gulf, Biloxi, Miss.  
April 2-4—Ohio Hospital Association, Columbus.  
April 5-7—Carolinas-Virginias Hospital Conference.  
April 8—Tennessee Hospital Association, Chattanooga.  
April 8-11—Association of Western Hospitals, Hotel Biltmore, Los Angeles.  
April 11-12—Mid-West Hospital Association, Kansas City, Mo.  
April 17—Alabama Hospital Association, Birmingham.  
April 22-24—Iowa Hospital Association.  
May 1-3—Tri-State Hospital Assembly, Hotel Stevens, Chicago.  
May 8-10—Hospital Association of Pennsylvania, William Penn Hotel, Pittsburgh.  
May 22-24—Hospital Association of the State of New York, Buffalo.  
May 23-25—Minnesota Hospital Association, Minneapolis.

### Minnesota Nurses Convene

The annual meeting of the Minnesota Nurses' Association, held at the College of St. Teresa, Winona, Minn., September 7 to 9, was attended by approximately 300 nurses. Business sessions and discussions of various nursing problems occupied the delegates on Thursday and Friday, September 7 and 8, and on Saturday the scene of activities was shifted to the Mayo Clinic at Rochester where a series of lectures, clinics and demonstrations was presented.

Governor Harold Stassen spoke on "Citizenship in a Democracy."

### Goldwater Submits Building Program

A proposed building and improvement program calling for an expenditure of \$102,532,507 over a six year period has been submitted to the New York City planning commission by Dr. S. S. Goldwater, commissioner of the department of hospitals. Of this amount, \$25,445,547 is requested for pending and new projects for the current year and the remaining \$74,153,960, according to the proposal, is to be spent for new hospitals, additions to existing buildings and general expansion of plant.

## The Sweetland WARMER and CAST DRIER

U. S. Patent 2,122,964

Other Patents Pending



The above photograph shows the Sweetland Warmer and Cast Drier about to be used for drying a hip-spica. The flexible mat is wrapped around the cast and provides air space through which air from the warming unit circulates in direct contact with the cast. Reduces drying time from days to hours.

The Modern Method for

—Warming Patients in Shock  
—Drying Plaster Casts  
—Warming Post-Operative Beds  
by the

controlled circulation of warm air.

SCIENTIFICALLY designed for rapid and convenient bed warming and cast drying. Even temperature is maintained and can be adjusted for "low," "medium" and "high." All parts contacting the bed are free from electric wires and the dangers of electric shock. Thermostatic control prevents temperature from rising above a predetermined maximum.

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## **CRUTCH TIP**

Built for hard wear; rugged throughout. The base area is more than three times that of usual crutch tip; the ferrule hole is more than twice as deep. Concave base creates an automatic vacuum-suction, holding crutch firmly to the ground at any angle. Wear-resistant plug in center. Packed one pair in box. Made in one size only.

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## Medical Record Librarians Will Hold Joint Meeting With College of Surgeons

Dr. G. Harvey Agnew, president of the American Hospital Association, who was scheduled to speak on "The Importance of an Efficient Medical Staff to a Hospital," at the hospital standardization conference of the American College of Surgeons in Philadelphia, October 16 to 19, will not be able to attend the meeting. Dr. Eugene Walker, superintendent of the Springfield Hospital, Springfield, Mass., will talk on this subject.

A joint conference with the American Association of Medical Record Librarians is planned for the morning of October 18. Lillian H. Erickson, St. Luke's Hospital, Chicago, who is president of the librarians' association, will outline the present status of the training of medical record librarians; Henry H. Caldwell, a member of the Chicago Bar Association, will discuss "Legal Aspects of Medical Records," and Genevieve Hilger, superintendent and medical record librarian of Decorah Hospital, Decorah, Iowa, will speak on "What We Have Done to Overcome Difficulties in Obtaining Good Medical Records in the Small Hospital."

## New Wing for South Nassau Hospital

Plans are under way for a new wing and alterations that will increase the capacity of the South Nassau Community Hospital, Rockville Center, N. Y., from 66 to 135 beds. Included in the modernization program, which will cost approximately \$250,000, are a new kitchen, an operating suite, a laundry and a power plant. The architect is William T. McCarthy, Brooklyn, N. Y., with Charles F. Neergaard as hospital consultant.

## Insist on Cash for Your Discarded X-Ray Films

Used or spoiled x-ray film, often disposed of by hospitals to companies that reclaim it, had better be sold on a spot cash basis only. This is the opinion of authorities from whom *The Modern Hospital*, in the interests of its readers, has recently sought counsel.

Although there are reliable companies that buy discarded x-ray films, some of them are small and lack funds for prompt payment; other companies have proved to be dishonest.

The old film has value because of its silver content and its cellulose acetate base. The base is used largely in the manufacture of novelties, such as transparent boxes and windows or frames


for bill folds, license cases and the like. The recovery of the silver content is merely incidental for the cost is relatively high in proportion to the quantity of silver recovered.

## Marine Ambulance Service Established at Miami Beach

A new marine ambulance and medical consultation service to ships at sea was recently inaugurated by the U. S. Public Health Service. This is an extension of the department's medical consultation service by radio. Because of the peculiar land contour and location of the Gulf Stream current, hundreds of ships round the Florida peninsula every year without stopping and run a course just off Miami Beach.

The foreign quarantine division of the Public Health Service will maintain a sea going ambulance at Miami Beach Buoy and the hospital division will take care of sick and injured persons who may need to be removed from ships.

In the opinion of the public health service officials, many of the illnesses and injuries that occur can best be treated on board ship; under the new arrangement, a physician will be sent out to the vessel whenever the ship's captain requests such assistance.



*The Softest*

# Sanitary Napkin

*Known!*

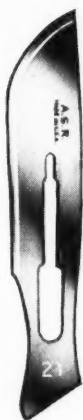
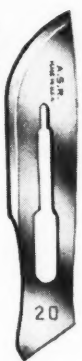
Fluffy Absorbent Cotton, covered with soft tubular stockinette. No edges, no seams, smooth sides.

Sizes No. 6, No. 8, No. 10.

Samples and prices gladly furnished on request.

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The long experience of this Company in the manufacture of precision edges insures the surgeon of a blade exactly suited to his requirements. Developed after careful research and frequent consultation with leading surgeons, A. S. R. Surgeon's Blades are uniform and possess the degree of keenness found most satisfactory to operators. They are manufactured under exclusive processes which are the results of latest findings in metallurgy. A. S. R. Surgeon's Blades are available in nine standard types.

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## SURGEON'S BLADES

*and Handles*

# Names in the News

## Administrators



FRED M. WALKER has resigned the position of superintendent of the Duval County Hospital, Jacksonville, Fla., to become director of the new Charlotte Memorial Hospital, Charlotte, N. C. Mr. Walker has been head of the Jacksonville hospital since 1926.

He is a charter fellow of the American College of Hospital Administrators and was the organizer and first president of the Florida Hospital Association.

DR. R. A. CUSHMAN, who has been superintendent of the Mendocino State Hospital, Talmadge, Calif., for the last seven years, has tendered his resignation, effective October 1. Doctor Cushman, at 83, is one of the oldest

physicians in the state. He is retiring after fifty-six years of professional activity. DR. WALTER A. RAPAPORT has been named to succeed Doctor Cushman.

TOLBERT TERRELL has resigned as manager of the Wilson N. Jones Hospital, Sherman, Tex. He is planning to devote the next few months to advanced study in hospital administration, after which he will take a position in Fort Worth, Tex.

DR. CHARLES B. ODOM and DR. J. O. WEILBAECHER JR. have been named assistant directors of the Charity Hospital, New Orleans. The appointments were made by the board of trustees at the same time that Dr. ROY W. WRIGHT was made director of the hospital, succeeding Dr. GEORGE S. BEL.

MRS. EVA BATCHELDER BERRY, R.N., recently assumed the duties of superintendent of the Woman's Hospital, Batavia, N. Y., succeeding HAZEL HALLET, who resigned last July. Mrs. Berry, then Miss Batchelder, served as head of the Moses Taylor Hospital,

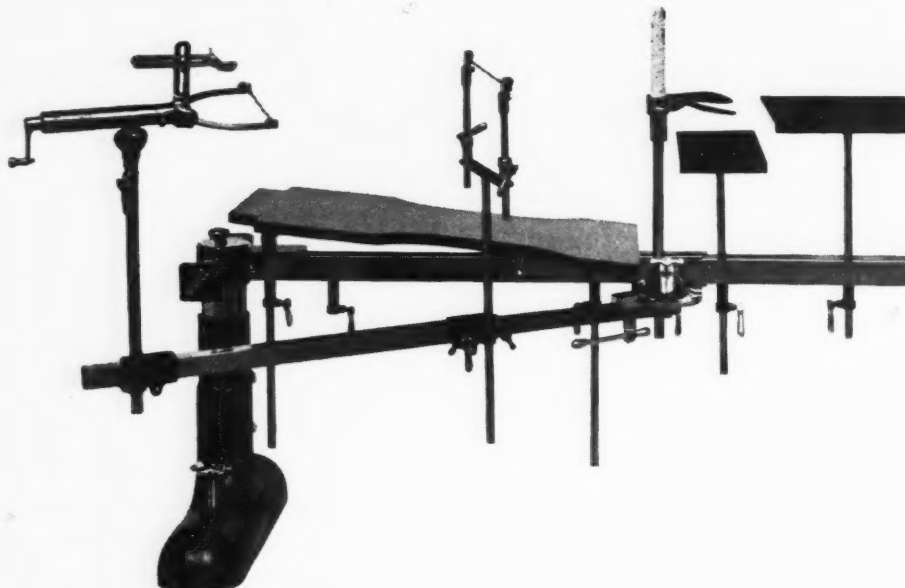
Lackawanna, N. Y., from 1925 to 1931, when she resigned her position to be married. After the death of her husband she again became active in the hospital field.

CHARLES E. CROFT, formerly associated with Montefiore Hospital, New York, has been appointed superintendent of the Yonkers General Hospital, Yonkers, N. Y. Mr. Croft succeeds MRS. GRACE L. MCKELVEY, who resigned after ten years of service.

DR. BART W. DORBANDT, superintendent of the Wichita Falls State Hospital, Wichita Falls, Tex., since 1937, has been reappointed to that position for another two year term.

SISTER M. GISELLA, R.N., superintendent of the Sacred Heart Hospital, Allentown, Pa., has relinquished her duties as head of the hospital to assume a similar position at St. Joseph's Health Resort, Wedron, Ill. SISTER M. SEVERINE, R.N., has been named to succeed Sister Gisella.

DR. O. N. ANDERSEN has been appointed assistant medical superintendent of the Barnes Hospital, St. Louis. Doctor Andersen was formerly associated with the council on medical education and hospitals of the A.M.A.



- ★ A two-thirds view of the newly designed "Model B" Bell Orthopaedic Table showing skeletal traction attachments.
- ★ Pin tractor inserted in place of bandage foot piece.
- ★ Both traction and counter-traction pieces fully adjustable to height, rotation, etc.
- ★ Pin tractors may be converted to wire tractors.
- ★ Traction mechanism attached to over-head frame for fore-arm reductions. (Complete Bell over-head frame is standard equipment, not shown in the photograph.)
- ★ Easily accessible for x-ray or fluoroscopy.
- ★ Universally adjustable x-ray cassette holder also available.
- ★ Refer to September issue of The Modern Hospital for full length view of the "Model B" Bell Table.

This newly designed "Model B" of the Bell Fracture Orthopaedic and X-ray Table will next be exhibited at the American College of Surgeons Meeting in Philadelphia, October 16th to 20th. Demonstrations in Booth 18.

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as it can be applied *right over* old ceilings. Let a Celotex Acoustical Expert make a FREE Noise Survey of your hospital, without obligation! He will locate the principal noise sources, and tell you *how little it will cost* to remedy them with this proved, permanent method! Mail the coupon!

*The word Acousti-Celotex is a brand name identifying an acoustical product marketed by The Celotex Corporation.*



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Please have a Celotex Acoustical Expert make a FREE Noise Survey of our hospital. Also send your valuable booklet, "NOISE," and your magazine, "QUIET FORUM."

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Address .....

City .....

County.....State.....

CHARLES GORDON BECK, manager of the Veterans Administration Facility, Des Moines, Iowa, has been named manager of the Veterans Administration Facility at Hines, Ill., succeeding COL. HUGH SCOTT, who retired on September 1.

SISTER M. SUITBERTHA, for the last eight years superintendent of the Mary Immaculate Hospital, Jamaica, N. Y., and SISTER M. EUGENIE, superintendent of St. Catherine's Hospital, Brooklyn, N. Y., have exchanged posts. Sister Suitbertha served at St. Catherine's from 1904 to 1907 before going to Jamaica. Sister Eugenie was at Mary Immaculate Hospital for the first twenty-seven years of its existence.

#### Department Heads

BELLE YOUNG, formerly connected with the Knickerbocker Hospital, New York, has been appointed dietitian at Physicians Hospital, Jackson Heights, N. Y.

DR. RIGNEY D'AUNOY has resigned his duties as dean of the Louisiana State University medical center in New Orleans and as chief of the pathology department of the Charity Hospital, it has been announced. Doctor D'Aunoy submitted his resignation on the grounds that his duties were too nu-

merous for him to handle without endangering his health. He will continue to serve as medical consultant on the new Charity Hospital building and as professor of pathology and bacteriology at the university.

MARGARET BENNETT has been made director of the dietetic department of the Pennsylvania Hospital, Philadelphia. ALICE MCCOLLISTER of New York will serve as consultant.

DR. T. MARSHALL WEST has been named president of the staff of the Williamsport Hospital, Williamsport, Pa. DR. HAROLD L. TONKIN was elected vice president and DR. W. W. WILCOX was reelected secretary-treasurer.

#### Trustees

C. MCGREGORY WELLS JR. was unanimously elected president of the Harrington Memorial Hospital, Southbridge, Mass., at the annual meeting of the board of directors. Other officers elected at the meeting include: ROBERT P. MONTAGUE, vice president; ALFRED J. PELOQUIN, treasurer, and IRVING L. RICH, secretary.

GEORGE M. ARISMAN has been chosen president of the board of directors of the Lancaster General Hospital, Lancaster, Pa., to succeed B. FRANK

SNAVELY. Other officers elected to the board include: PAUL A. MUELLER, vice president; HAROLD ADAMS, secretary, and JOHN J. ESHELMAN, treasurer.

MORTIMER Y. FERRIS has resigned as president of the board of trustees of the Moses-Ludington Hospital, Ticonderoga, N. Y., after twenty years of service. CHARLES A. HUNT was appointed to fill the vacancy caused by Mr. Ferris' resignation. Other officers named to the board are FRANK MOSES, first vice president; STEPHEN J. POTTER, second vice president; KIRBY D. WILCOX, secretary, and BRADLEY E. STAFFORD, treasurer.

MAURICE L. WURZEL was reelected president of the board of trustees of Mount Sinai Hospital, Philadelphia, recently. Others named for a one year term were: DR. LOUIS SUSBAUM, first vice president; SAMUEL H. DAROFF, second vice president; HARRY SYOK, treasurer, and EMANUEL ROSENFELD, secretary.

HENRY M. BRUNNER was reelected president of the Columbia Hospital, Columbia, Pa., at the annual meeting of the board of directors. JAMES W. STAMAN, vice president, and ROY K. GARBER, secretary-treasurer, were also reelected.

## Wards as Attractive as Private Rooms . . .



If you could have your wards look home-like instead of barracks-like, you would, wouldn't you? Well, you can—thanks to HILL-ROM furniture. As a matter of fact, many hospitals already have equipped their wards with HILL-ROM fine wood bedsteads, dressers, tables, chairs. It has done much to take off the "institution" curse.

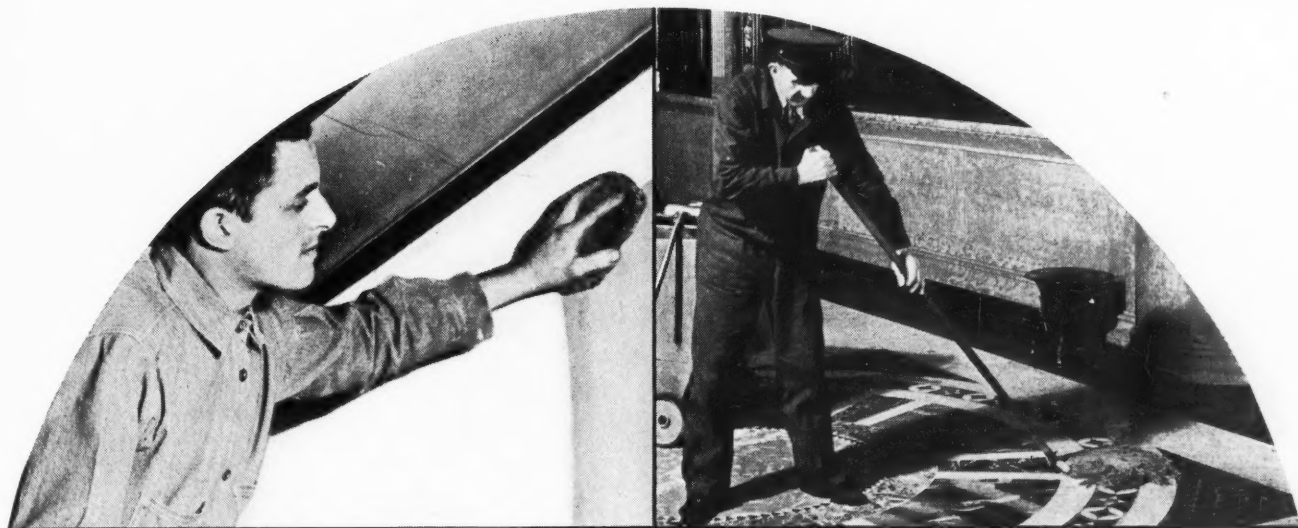
The need for economy in ward furnishings need not interfere. The HILL-ROM line is complete with matched suites and single pieces at prices covering a wide range. You can revolutionize the appearance of your wards at little if any additional cost. It will be well worth your while to look into the matter. Write and say when you would like a consultant to call.

(Left) A HILL-ROM-furnished ward.



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Makers of ARTISTIC FURNITURE and EQUIPMENT for HOSPITALS

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One pound of Wyandotte Detergent will clean 230 of the dirtiest washbowls you can find. 24 washbowls can be cleaned twice a day, six days a week for one year with the contents of a 75-lb. drum—with enough left over to wash 5000 square feet of painted surface.

## 312 TIMES FOR ONE DOLLAR

For less than a dollar you can mop one hundred square feet of flooring six nights a week for 52 weeks with Wyandotte Detergent. Here, too, its quick-acting, free-rinsing qualities save you money in labor and material cost.

## SEVEN CENTS PER SQUARE FOOT

Where marble is already stained or discolored—even though the discoloration should be of many years' standing, a poultice made of Wyandotte Detergent and water will draw out the stain and restore the marble to its original color. And the cost for Detergent and labor is only 7 cents per square foot!



**T**HINK of the great convenience of having to use only *one* efficient detergent. Bought in larger quantities, the price is lower. And, because every particle of Wyandotte is 100% cleaning agent, a little goes a long way. You're sure that Wyandotte Detergent will not

harm any surface that water won't harm, and with Wyandotte Detergent you get *Wyandotte Service*.

There are Wyandotte Service Representatives in all parts of the country. . . . Why not call *your* Wyandotte man now?



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WYANDOTTE MICHIGAN

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## Deaths

DR. JOSEPH A. BRADY of St. Vincent's Hospital, New York, died of heart disease after an illness of six weeks. Doctor Brady had been associated with St. Vincent's Hospital for thirty-five years and had served as a member of the executive committee of the medical board and as director of the first surgical division of the hospital.

DR. JACKSON J. AYO, superintendent of the East Louisiana State Hospital, Jackson, La., died recently after a long illness.

## Administrative Setup Reorganized

As the result of a survey made by the superintendent of charities to determine the needs of the hospital, the position of executive superintendent of the Los Angeles County General Hospital, Los Angeles, has been abolished by the county board of supervisors and a new post, that of director, has been created. The board has accepted the resignation of Everett J. Gray, who has served as executive superintendent of the hospital for the last two years. The new director of the hospital will be required to have a medical degree and will be selected through a civil service examination.

## New Ellis Hospital Unit Opened

The new unit of Ellis Hospital, Schenectady, N. Y., was opened on July 1, bringing the capacity of this institution to 360 adult and 60 infant patients. The five story addition contains 103 beds and enlarged space for many of the hospital departments. The growth of Ellis Hospital was described in an article by the president of the board of trustees in the May issue of *The Modern Hospital*.

## Two Hospitals Merge to Make Charlotte Memorial Hospital

The new Charlotte Memorial Hospital, now under construction at Charlotte, N. C., will provide a 300 bed hospital and a 50 bed nurses' home at a total cost of approximately \$1,000,000. The funds have been provided by popular subscription, by a city bond issue and by a grant of \$450,000 from PWA.

Two existing hospitals are to be merged in the new plant: St. Peter's Hospital and Good Samaritan Hospital. Both are general hospitals, the former for white patients and the latter for colored. The new hospital will be maintained by the city but will have its own board of directors.

The move to have a consolidated

hospital was initiated by the physicians of Charlotte under the direction of a committee headed by Dr. W. Z. Bradford. At present no hospital in Charlotte is approved for the training of interns. Walter W. Hook of Charlotte is the architect and Dr. William H. Walsh of Chicago made the original survey and has been the consultant.

## Foundation Gives New Wing

Construction of a six story addition to the Monmouth Memorial Hospital at Long Branch, N. J., to be known as the Borden Memorial Pavilion, was started in July. The new addition comes as a gift from the Mary Owen Borden Memorial Foundation and will be devoted to the care of children and private patients.

## Hospital Starts Ambulance Service

After thirty years without any ambulances, Roosevelt Hospital, New York City, has purchased and put into operation two ambulances of the latest type. These white ambulances are housed in the stables in which the horse drawn ambulances were kept thirty years ago. The new vehicles have been in use for three months and are a source of pride.

## AS ONE PHYSICIAN TO ANOTHER...

### In Treating Constipation, This is What 9 Physicians Out of 10 Would Say . . .

New habits of elimination, new dietary habits are the basis of most successful treatment. However, in aiding in the re-establishment of such habits, a bland pure mineral oil may often be most helpful. And now, in light of recent studies upon the effects of Vitamin B-1 in the gastro-intestinal tract, this important food factor may be an essential in restoring normal tonus to the neuromuscular mechanism of the intestines.



### Both of These Important Aids are Present in Vita Nujol!

**VITA NUJOL** is a pleasant tasting mineral oil emulsion with pure crystalline Vitamin B-1 added. The concentration of the vitamin is such that the recommended average dose of Vita Nujol contains the average maintenance requirements for an adult (400 International Units).

**VITA NUJOL** will be found to be helpful not only in the treatment of

constipation, but wherever Vitamin B-1 deficiency may be a factor. This includes such conditions as loss of appetite, the toxemias of pregnancy and chronic alcoholism, gastric and duodenal ulcers, and many other common syndromes

A postal card brings you free samples and descriptive literature. Stanco Incorporated, 1 Park Ave., New York, N. Y.

**VITA Nujol**



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No panels to require changing or replacement; no laundry bills or repair costs . . . the Venetian Blind principle shuts out direct sunlight without shutting out air; permits easy adjustment to deflect air currents upward or at any desired angle; admits fresh air without subjecting the patient to dangerous drafts. May be closed completely, if desired. Provides full privacy for the patient. Slat adjustments easily regulated by a convenient dial at top of screen.



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Things like the Venetian Screen don't "just happen". Someone has to recognize the need for improvement, figure out practical means for meeting the need, and make the finished product available to those who have use for it.

Keeping hospitals supplied with staple, standardized hospital merchandise is important. Will Ross does that . . . to the extent of some 6,000 items. But advancing hospital science so that the sick may be better served . . . that is equally important. The Kenwood Venetian Screen is a typical example of a Will Ross Development . . . one of many that we have been happy to add to hospital progress.



**WILL ROSS, INCORPORATED**

*Wholesale Distributors and Manufacturers  
of Hospital Supplies*

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## BOOKS ON REVIEW • • •

**HOSPITAL PUBLIC RELATIONS.** By Alden B. Mills. Chicago: Physicians Record Company, 1939. Pp. 384. 16 page illustrations. \$3.75.

Social service institutions, no less than industrial organizations, are increasingly recognizing the necessity of shaping public attitudes. But though the recognition exists, there are ignorance and confusion as to the philosophy, scope and technics of public relations. This form of applied social science until recently has been confined to such a relatively small area that even its practitioners have had difficulty in analyzing its principles.

Mr. Mills' comprehensive book of 14 chapters, 5 appendices and 16 illustrations is the first to deal specifically with public relations of hospitals. However, as Edward L. Bernays, pioneer public relations counsel, points out in his preface, "Hospital Public Relations" is so broad in its treatment that it is applicable to the public relations of social service institutions generally.

The book has two main divisions: the first of which can be defined as the theory and the second, as the prac-

tice of public relations. For the specific public to which it is addressed, such as hospital administrators, trustees and staff, Mr. Mills' study has distinct virtues. It is clear and understandable because it is so specific; the second section particularly illuminates the first. It is not pompous or vague, as so many books in this field are.

Clarity, however, is not achieved by an elemental approach or by a refusal to consider unresolved theoretical aspects of the subject. In the chapter, "Influencing Public Opinion," the author undertakes a discussion of such fundamental questions as the psychological bases of public opinion. Chapter 3, "Principles of Public Relations," is an analysis of various efforts of practitioners of public relations to provide a systematic statement of principles. Through this examination and by his own contributions, the author synthesizes a series of 20 principles of a hospital public relations' program. If the result is not entirely what a scientific student of the subject, such as Lasswell, would produce, it is certainly a sound statement of guiding rules for

a program. In both these chapters there is the very decided virtue, characteristic of the book, of simplicity and directness that makes for intelligibility.

This book emphasizes throughout the fact that the best public relations' appeal is the rational, rather than the emotional; that for hospitals the only basis of public relations is a service that best meets the needs of the public. Mr. Mills' technical knowledge of hospitals enables him to define what the best service should be.

The second section, on practical application, is explicit, documenting the theory so plainly by numerous specific examples that the most uninformed reader should be able to attain an understanding of method. The chapter on annual reports is highly informing; that on newspapers is recommended to those institutions that are annoyed or bewildered by the press. Chapter 13, "Joint Public Relations' Programs," provides a good description of co-operative public relations by hospital associations, a phase of the subject which, if industrial experience is any precedent, will be given greater attention as the individual hospitals become convinced of the usefulness of public relations.—W. V. MORGENSTERN, *director, Department of Press Relations, University of Chicago.*

*This advertisement created so much favorable comment, we are using it again.*

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TRADE-MARK

Quality is independent.

IT COMES ONLY TO THOSE WHO SEEK IT.

It will not be where it is not appreciated.

It enriches those who possess it, and continues to serve when all else has gone.

Every surgeon prefers quality instruments, and can have them if he will SPECIFY AND INSIST.

The slight additional cost is of small significance.

INSTRUMENTS BOUGHT ON PRICE SOON PASS AND ARE FORGOTTEN. QUALITY ALONE ENDURES.

Kny-Scheerer instruments wear well, become old friends, and, like old wine, gladden the owner.

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—(The Quality House)—

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The Kny-Scheerer Corporation was taken over by the United States Government, and sold by the alien property custodian in 1919 to Americans, and has so remained. The staff is composed entirely of Americans, and is conscientiously devoted to the one purpose of serving our industry in America.



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*in most cases . . . in most hospitals*

**it's U.S.I. and WEBB'S PURE**

# **ALCOHOL**

# RELAXATIVES . . . . .

## HOSPITAL MOTHER GOOSE

- Old Mother Hubbard went to the cupboard;  
My, wasn't she the chump!  
To take bichloride for a pain in the side—  
We used the stomach pump.

## The Retort Courteous

- C. Rufus Rorem of the Commission on Hospital Service deplores the use of the word "diagnosis" as a "confusing term." He advocates the use of simple terms which the layman can understand.—NEWS ITEM.

Strange medical terms for diseases and germs  
Are foreign and apt to inflame.  
There's no reason to speak either Latin or Greek,  
Our freedom we loudly proclaim.  
The laymen are wise to the medical guys;  
The crusaders vow to debunk,

They say "diagnose" is professional pose  
And technical verbiage is junk.

One syllable words will appeal to the birds  
Who drool as they read with their lips.  
Don't muddle and curdle and say  
"pelvic girdle"  
When what you allude to is hips.

"Abdomen's" a word that, of course, is absurd,  
While paunch is a beautiful name.  
Why speak of "rhinitis" or say "pharyngitis"?  
A cold in the head is the same.

"Appendix acute"? Don't operate, brute,  
It's only a "gripe in the guts."  
Don't say he's "psychotic" or even "neurotic,"  
Just write down the fact that he's nuts.  
With nonchalant grace one should speak of a place  
Where nature indulges a bump.  
Though the "gluteal zone" may support the backbone,  
Refer to it simply as rump.

Life is worth living if blood is life giving,  
"Anemia" is just a bon mot.  
Don't call it pernicious; it's really delicious,  
Depends on the liver, you know!

The Queen of Spain said as she took to her bed,  
"It was, it will be, it is now."  
Obstetrics well meant is a "blessed event,"  
The same for a queen or a cow.

The New Deal has come to the aid of the dumb  
And science must take off its shirt,  
For democracy calls and all medical scrawls  
Henceforth shall be simple and curt.

O say, can you see what a change there will be  
When healers no longer are heels.  
When the language they use to confound and confuse  
Will be simple as "Take after meals."

Streamlining the talk of the medical doc  
May modernize some of our ills, BUT  
The World of Tomorrow will still have some sorrow  
Till we streamline our medical bills.  
—B. C. M.

## STERILE! THE WATCHWORD OF EVERY HOSPITAL

Super cleanliness, the essential of every hospital, is attained when equipment is easily cleansed. Trays made of Boltalite have a smooth dense surface which will not harbor germs. All edges and corners are rounded to add strength and facilitate cleaning. These trays are solid Boltalite, which means that there is no surface finish to chip, crack, peel or scratch. The rich mahogany color is an integral part of the tray and cannot change, even though trays are sent through the dish washer at high temperatures many times.

Boltalite Trays are *quiet* and reduce noise in kitchens, corridors, wards—in fact, at every point where dishes are handled. Ask your equipment dealer to tell you more about these quiet, trouble-proof, sanitary trays, or use the handy coupon below.

## THE BOLTA COMPANY

LAWRENCE

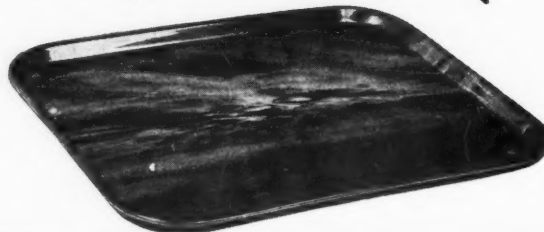
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Gentlemen: Kindly send me information about the complete line of Boltalite products.

Name .....  
Position .....  
Hospital .....  
City ..... State .....



## BOLTALITE



# HOSPITALS SAVE UP TO 40% ON DISINFECTION!

**BUY "LYSOL" IN BULK!**



**Save up to 40%  
a gallon**

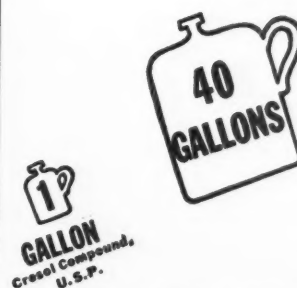
On 50-gallon contracts, delivered as needed, 10 gallons at a time, "Lysol" costs you as little as \$1.25 a gallon. A real saving.

## WHY "LYSOL" COSTS LESS TO USE

One gallon of "Lysol" disinfectant (phenol coefficient 5) makes 100 gallons of disinfectant solution of proper strength to comply with official requirements for a general disinfectant solution.



One gallon of Cresol Compound U. S. P. (phenol coefficient of 2) makes only 40 gallons of solution of comparable strength.



"LYSOL" is cheaper to use not only for disinfecting fine instruments and equipment, but also for scrubbing, cleaning and general disinfection use. Hospitals save two ways with "Lysol". By buying "Lysol" in bulk, they save up to 40% a gallon on price. They save 50% or more in use, because "Lysol" goes twice as far as cheaper cresol compounds (which have a phenol coefficient of 2 or less, while "Lysol's" is 5).

"Lysol" is the effective, economical disinfectant for rubber gloves, sheets, pads, etc. It does not affect these materials. For boiling instruments, "Lysol" solution helps eliminate corrosion, preserve fine cutting edges.

1889 • 50TH ANNIVERSARY • 1939



## HOW TO ORDER "LYSOL"

The sale of "Lysol" in bulk is restricted to hospitals. Order direct from Lehn & Fink Products Corporation or from the following authorized distributors:

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Littlefield Bldg., Austin, Texas

STRIEBY & BARTON LTD.  
912½ E. Third St., Los Angeles, Calif.

SURGICAL SELLING COMPANY  
139 Forrest Avenue, N. E., Atlanta, Ga.

Address inquiries regarding orders, shipments, etc., to any of the above or direct to

LEHN & FINK PRODUCTS CORPORATION  
Hosp. Dept. M. H.-910, Bloomfield, N. J., U. S. A.

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# READER OPINION

## General Articles Requested

Sirs:

We wish to subscribe to your publication. We were subscribers for a number of years and I doubt if we obtained the benefit from publication that we should and I am convinced that it was our own fault. With our resubscription I am going to handle each issue on a different basis in that I am going to scan the various articles very carefully and, after I have finished the magazine, send it to the various department heads with a notation of the article in which they should be especially interested and ask them to give it a careful perusal.

I can say with every sincerity that I was well pleased with the general issue both as to the number of subjects covered and the manner in which they were covered. My only criticism, if I have any, is a general one that, in most hospital magazine articles, the author goes into too much detail. No two institutions are alike and any ideas that are gained from the experience of others must be translated into the peculiar situation in each institution.

Therefore, I always read the articles that generalize on a particular subject and am likely to pass over the ones that go into minute detail.

C. P. Wright,  
Superintendent.

General Hospital,  
Syracuse, N. Y.

## Call for Help

Sirs:

An urgent request for hospital equipment has just reached our bureau from the hospitals of West China. Doctor Lim, director of the National Red Cross Society of China, Medical Relief Corps, begs us to give this request wide publicity in this country and to point out to hospital administrators that even obsolete equipment will be welcomed in the Chinese base hospitals.

A list of the immediate needs of the Chinese hospitals includes the following items:

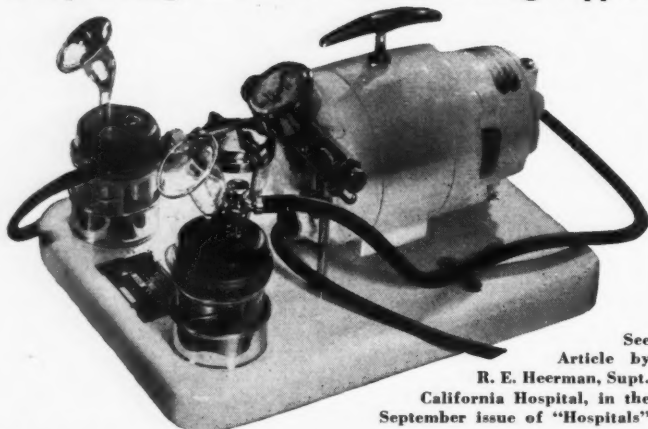
Bedpans .....	14,000
Urinals .....	28,000
Wash basins .....	16,800
Bath basins .....	5,600

Tooth cups .....	70,000
Tooth brushes .....	70,000
Flasks (1000 cc.) .....	5,600
Measuring cans (1000 cc.) .....	2,800
Rectal tubes .....	2,800
Mouth thermometers .....	28,000
Rectal thermometers .....	8,400
Sphygmomanometers .....	1,400
Hot water bags .....	5,600
Ice cups .....	5,600
Rubber catheters .....	5,600
Enema sets .....	5,600
Cotton mattress covers, 80 in. by 33 in. ....	105,000
Large cotton sheets, 94 in. by 53 in. ....	105,000
Oil cloth or rubber draw sheets, 53 in. by 29 in. ....	70,000
Draw sheets, 66 in. by 38 in. ....	175,000
Bed pads (quilted protectors for mattresses), 24 in. by 19 in. ....	175,000
Pillow cases, 24 in. by 17 in. ....	140,000
Blankets .....	21,000
Pajama suits .....	175,000
Bath towels .....	105,000
Medium funnels .....	4,200
Measuring glasses (10 cc.) .....	2,800
Measuring glasses (30 cc.) .....	2,800
Dressing rubbers, 16 in. by 2 in. ....	5,600

Co Tui, M.D.,  
Director.

American Bureau for  
Medical Aid to China, Inc.,  
New York, N. Y.

## GUARD AGAINST DANGER of Spreading Infection and Lacerating Nipples



See  
Article by  
R. E. Heerman, Supt.  
California Hospital, in the  
September issue of "Hospitals"

## GOMCO Electric Breast Pump

How the unique principles of the Gomco Electric Breast Pump increase milking efficiency and overcome the present hazards in the use of breast pumps is set forth in the report of investigations by the California Hospital. Spreading of infection is avoided by continuous suction, eliminating the recirculation of contaminated air as in intermittent type pumps.

The intermittent milking action is under the control of the patient, who can vary it to suit her individual requirements. This, plus the new design of the applicator, permits the natural massaging action of atmospheric pressure, providing greater comfort, safety and efficiency.

Ask your regular dealer to demonstrate these and the many other important exclusive features of the professionally designed Gomco Electric Breast Pump.

GOMCO SURGICAL MANUFACTURING CORP.  
87-91 ELLICOTT ST.      BUFFALO, N. Y.

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## FORRESTER CERVICAL COLLAR



A comfortable appliance for ambulatory cervical fractures. Adjustable chin and head supports for elevation and extension... made with chin rest and straps for proper fitting. No. 121 comes in three sizes, adult, medium adult and child.

DE PUY MFG. CO.  
WARSAW, IND.

# CEASE Lunch System

QUALITY FOODS ALWAYS

COMMISSARY BAKERY AND  
GENERAL OFFICES -- DUNKIRK, N. Y.

July 22, 1939

Edison General Electric  
Appliance Company  
5600 West Taylor St.  
Chicago, Ill.

Attention Mr. Jack Welch

Dear Mr. Welch:

Serving 12,000 meals daily to the industrial workers of western New York has permitted us an opportunity to try many types of food warmers.

We are happy to advise you that in both the public lunch room and dining room we have just completed in connection with our new commissary building, we have installed Edison Hotpoint food storage tables.

We have found the individual control of each food unit together with a constant dependable heat, provide a food storage service which we have been unable to procure in any other type of equipment.

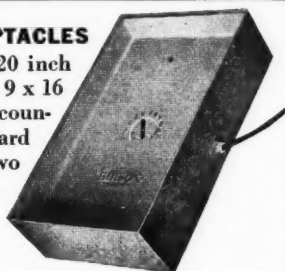
Very truly yours,

  
CEASE LUNCH SYSTEM  
"Quality Food Always"

## EDISON-HOTPOINT Provides Improved HOT FOOD STORAGE Service

### EDISON PAN RECEPTACLES

are available for 12 x 20 inch (known as No. 200) and 9 x 16 inch (known as No. 165) counter pans. Either a standard pan, divided pan or two half pans may be used.



**JAR RECEPTACLES** used for sauces, soups, gravies, and vegetables on hot food storage table—caramel and hot fudge syrup warmers at fountain lunch.

Edison-Hotpoint's Electric Hot Food Storage Receptacles do away with the food waste caused by "cooking out" foods in old fashioned steam tables. These modern Hot Food Storage Receptacles end the discomfort, uncertainty and expense of heat-waste.

These amazingly efficient new storage units, with cast-in Calrod heating elements, automatically hold the right temperature for each food, whether in the kitchen, bain-marie, service counter, or individual service station.

The right temperature for every food is quickly selected—automatically maintained. No water. No steam. No pipes. No drains. No valves. Take a tip from successful operators like W. W. Cease. Put the Edison money-making Hot Food Storage Receptacles to work for you now. Write for complete information.

EDISON GENERAL ELECTRIC APPLIANCE CO., Inc., 5662 W. Taylor St., Chicago, Ill.  
Distributed in Canada by CANADIAN GENERAL ELECTRIC COMPANY, Ltd., Toronto

For sale through Kitchen Equipment Houses

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EDISON

Hotpoint

COOKING  
EQUIPMENT

## IT'S SAID THAT—

The TRANE COMPANY, LaCrosse, Wis., has developed a single self-contained air conditioning unit, called the Trane Turbovac, that automatically supplies abundant chilled water for comfort air conditioning installations. . . . A booklet describing the uses of "Cavalon," rubber-coated upholstery fabric, has just been published by the Fabrikoid division of E. I. DU PONT DE NEMOURS & COMPANY, Wilmington, Del. The book presents the properties of this material and the testing methods used to evaluate these properties. . . . Positive circulation of room air, ranging from a gentle breeze to a 20 mile an hour gale, can now be obtained with the new 1940 model Silentaire window ventilator made by the BERGER MANUFACTURING DIVISION, REPUBLIC STEEL CORPORATION, Canton, Ohio.

The A. P. W. PAPER COMPANY, Albany, N. Y., has brought out something new in the way of waste receptacles for washrooms. The principal advantage of the new container is that the small opening at the top invites the user of the paper towel to crush the towel before placing it in the receptacle. Wadding the towel causes

the user to hold it for a time so that only one towel is needed to dry the hands, and towel consumption is consequently reduced. . . . The first catalog describing the new fluorescent lighting equipment now being marketed by EDWIN F. GUTH COMPANY, St. Louis, has just been released. The catalog features "Alzak" aluminum reflectors for use in combination with the fluorescent lamp.

The second edition of "Sterilization," a handbook for physicians, hospital executives and nurses, has just been published by the SCANLAN-MORRIS COMPANY, Madison, Wis. . . . The new Sanitex Panelette diaper, woven of either gauze or bird's eye cloth, has recently been marketed by the THOMAS TEXTILE CO., INC., 71 West Thirty-Fifth Street, New York. The diaper is so designed that it requires only one fold and eliminates excess cloth that may irritate the skin.

PAUL COSTE, INC., Providence, R. I., has introduced Airpath rubber tile flooring, which combines a relatively hard surface that is easy to clean with a resilience and softness that eliminate noise and add to foot comfort. . . . The control of noise transmission and of fire in air conditioning ducts is the subject of a new illustrated folder on Airacoustic duct lining sheets published

by JOHNS-MANVILLE, 22 East Fortieth Street, New York.

A new ambulance incorporating many advanced features of construction and design has been built for the Cincinnati General Hospital by SAYERS & SCOVILL COMPANY, Cincinnati. The ambulance, which is set up as a miniature hospital, is equipped with an emergency medicine cabinet and surgical instruments.

Cellular rubber pads for operating and examining tables are being manufactured by the VIRGINIA RUBATEX CORPORATION, Bedford, Va. The cellular material is a new type of rubber that is impervious to moisture and foreign matter and can readily be kept clean and fresh at all times.

FREDERICK E. HARTMANN, for the last six years general sales manager of the Baker Ice Machine Company, Omaha, Neb., died on August 7. Mr. Hartmann joined the Baker organization in 1905. . . . In addition to his duties as president of the Seamless Rubber Company, Inc., New Haven, Conn., F. THATCHER LANE has also been made chief executive of the Absorbent Cotton Company of America, Valley Park, Mo. H. Y. GRABAU has been appointed manager of the surgical dressings department of the Seamless Rubber Company.

# Gorham



**MANUFACTURES  
A COMPLETE LINE  
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Concentrated by a vacuum process that takes the water out without the use of high temperatures. Gets away from any "cooked" or "processing" taste—conserves the nutritional values natural to the fresh fruit juices.

Return the water and the reconstituted juice retains with remarkable fidelity the fruit flavors, vitamins and food values common to the fresh fruit juice.

Easily and quickly prepared—just add the water and mix. Hospital Administrators and Dietitians will find real economy in the use of these citrus concentrates—they eliminate the waste, decay, shrinkage and labor incident to the use of fresh fruit.

Juice costs per gallon:  
Orange, 60c; Grapefruit, 45c.

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